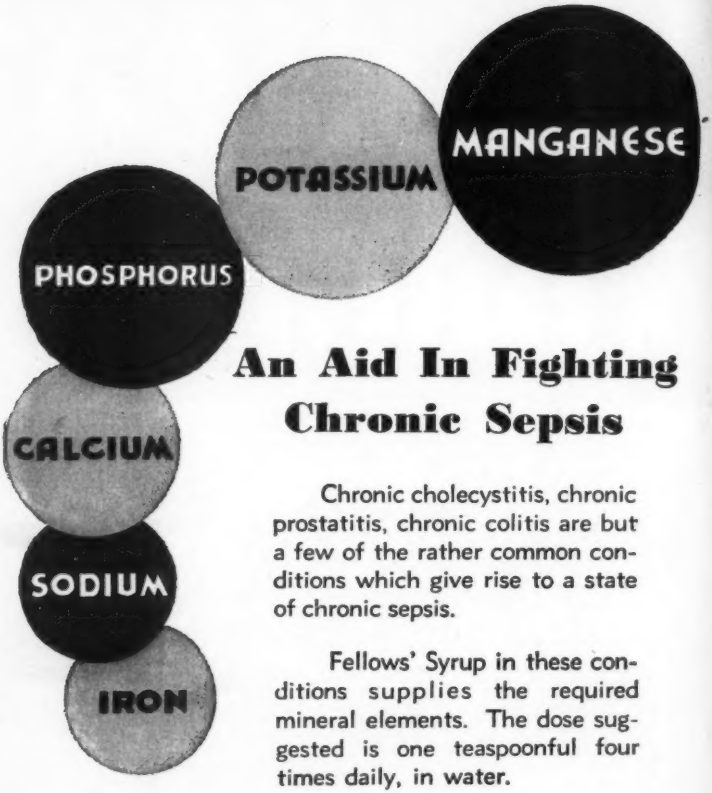
Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

• MARCH, 1934 • CIRCULATION: 128,000 •



An Aid In Fighting Chronic Sepsis

Chronic cholecystitis, chronic prostatitis, chronic colitis are but a few of the rather common conditions which give rise to a state of chronic sepsis.

Fellows' Syrup in these conditions supplies the required mineral elements. The dose suggested is one teaspoonful four times daily, in water.

FELLOWS' SYRUP

SAMPLES ON REQUEST

FELLOWS MEDICAL MFG. CO., INC.

26 Christopher Street, New York, N.Y.

MEDICAL ECONOMICS

The Business Magazine of the Medical Profession

MARCH, 1934 • VOL. 11, No. 6

25c a copy

$2 a year

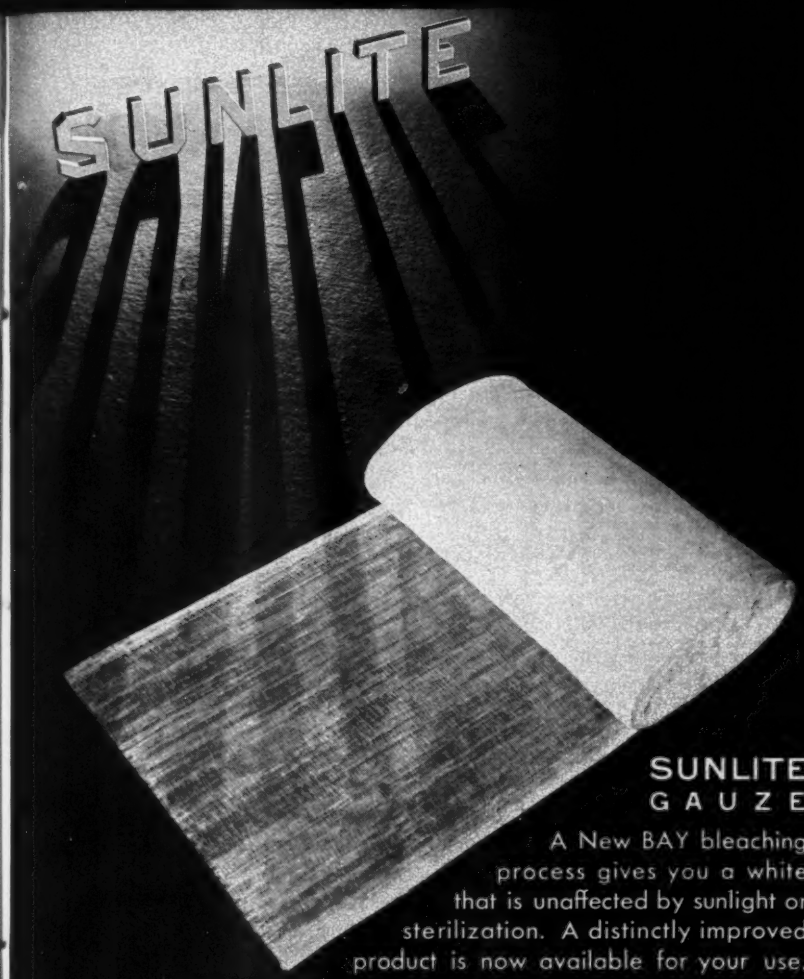
Published at RUTHERFORD, N. J., exclusively for physicians. Circulation, 129,000. (Copyright, Medical Economics, Inc., 1934)

Four Persons *unknown*

On a recent Thursday afternoon, an anxious mother in a small North Dakota village summoned the doctor to remove a bead from her baby's throat. To the hospital in the nearest large city they rushed the infant, hoping the necessary instruments would be at hand. There, the penniless mother was faced with disappointment. Nearly four hundred miles of snow-swept countryside still separated her boy from the nearest instruments that could save him from death by strangulation.

Yet the next afternoon he was recovering from a successful operation performed in a Minneapolis hospital. His mother is happy and grateful. Grateful to four persons whose names are unknown to her, whose kindness tipped the balance between life and death in favor of her boy. First, there is a taxi driver in Grand Forks, out of whose slim resources came the necessary railroad fare. On the train, a conductor provided food. A chance acquaintance rode past her own destination to comfort the mother en route. And, in Minneapolis, there is a minister who received advance word of the infant's arrival and arranged with a large hospital to have an ambulance rush him from train to operating room.

To these four people there is owing a debt of gratitude that cannot, perhaps, ever be expressed—and to a hospital staff that weighed its services in terms of human life rather than the exigencies of an already over-strained budget. And, in the last analysis, there is one more living tribute to the skill of a science that has progressed so far beyond the wine and oil that were once as freely administered on the road between Jerusalem and Jericho.



SUNLITE
GAUZE

A New BAY bleaching process gives you a white that is unaffected by sunlight or sterilization. A distinctly improved product is now available for your use.

THE BAY COMPANY
BRIDGEPORT, CONNECTICUT
A DIVISION OF
PARKE, DAVIS & CO.

THE BAY COMPANY, Bridgeport, Conn. **ME 3**

Gentlemen: Kindly send me a free sample of BAY'S Gauze.

Doctor.....

Street and Number.....

City.....*State*.....

Dealer.....

SPEAKING

Rally TO THE EDITOR: I wish to take this opportunity to express my agreement with the ideas expressed by Dr. E. H. Crane in his article "The Public Health League of America" in your January issue.

We of the rank and file of the profession are convinced that we have traveled far beyond the discussion age. We know that action along definite and constructive lines is what we need—and that at once.

Even at this late date it is not impossible, as some of our colleagues would have us believe, to rally to a common cause, and, by singleness of purpose and courage of mind, to carry the struggle to a happy ending.

Yours for arousing a sizable group to action.

Alfred Koerner, M.D.
New York City

Loans TO THE EDITOR: I have noticed in your magazine several articles about methods of collecting accounts. My own method, while different from all these, is equally efficient.

I suggest to patients who insist they can't pay me that, instead of making me wait, they borrow the money at some bank. Frequently they say they have nobody to sign the note with them. I meet this objection by offering personally to go on the note with them at the industrial bank to which I usually send my patients.

And when I am the one who agrees to sign the note, the patient can't very well refuse to go ahead with the loan. In four years I have collected over $5,000 in this way. Only once have I had to make good on a note, and that one was for $49 only.

Fred Leslie, M.D.
El Paso, Texas

Unethical TO THE EDITOR: One of the most serious complaints received by this Authority is the practice of rebating—that is, the giving of commissions by the retail pharmacist to the physician and the latter's acceptance of same.

While it is perfectly ethical and considered as no violation of the Retail Drug Code for a retail pharmacist to supply a physician with merchandise below cost, the gratuitous payment of any sum by the pharmacist to the physician based upon the number of his prescriptions filled is not only highly unethical but constitutes a definite violation of the Code of Fair Competition for the Retail Drug Trade.

We feel certain you will agree with us that such practices, while not reflecting a general condition, show an utter disregard for moral and ethical standards, and that every effort should be bent toward their elimination.

Samuel A. Weiss, Executive Secretary
Retail Drug Code Authority for
Greater New York

Correction TO THE EDITOR: We felt very proud to see the photograph and write-up of our headquarters building in January MEDICAL ECONOMICS.

However, I would like to call to your attention that the family from whom we receive the use of the building is the David Whitney family. We are so appreciative of their loan that we feel this error should be corrected in your next issue.

William J. Burns, Executive Secretary
Wayne County Medical Society
Detroit, Michigan

Stories TO THE EDITOR: As I glanced through my MEDICAL ECONOMICS for December, the article "Nativity" caught my attention.

This little story amused me highly, for it brought back the younger days when we all started out with such high hopes, but scared out of our wits. What a front we put on and how hard we tried to look wise and learned!

Give us more stories along the same line, for we are apt to forget those days. A little reminder of the hardships and fears in our own early days will make us more charitable to our younger brothers, more willing to help them when they are puzzled by some problem which we, with our experience, pass by with a smile.

W. S. Bennett, M.D.
Granville, New York

Easy Mark TO THE EDITOR: I congratulate you on your efforts to improve economic conditions among physicians. But the physicians must get together and do something for themselves. Let's forget Aesculapius and Hippocrates and just be honest business men. Those ancients don't help us much when we receive a dun for a past due bill.

I was an accountant before I entered medicine, and my attitude toward eco-

FRANKLY

nomic questions is bound to be different from that of the average physician without business experience. The impositions which fall to the physician are in my opinion appalling.

If a patient is honest with me and pays a little when he can, I will carry him as long as anyone, and charge it off if necessary. But when a patient owes me for several months and never comes around to see me, although I see him spending cash in the stores, then when he again wants medical attention I just tell him that I would like to take care of him but can not afford to.

I want such patients to advertise my attitude among others of his ilk. I may not get quite as much business, but the quality will certainly improve when the public comes to know that I expect pay for my services.

Of course, we are always going to be "taken in" on emergencies and on first visits; but it's our own fault if we don't determine the status of our patients before the second visit.

It is difficult for a physician just starting in practice to carry out such a program, but I feel that after a year in a community the time has come to put on the screws. The longer a physician permits himself to be an easy mark, the harder it will be to re-educate the public.

If every young physician would take this stand, there would undoubtedly be a marked improvement before long.

F. E. Newlove, M.D.
Lone Rock, Wisconsin

Plumbers TO THE EDITOR: The medical profession should be worried by the way the development of hospitals is tending to promote the loss of its independence. Most of the hospitals are lay owned and controlled, with more or less medical supervision by the lay boards.

The staffs in these hospitals must act dependently and timidly, for fear of offending the lay powers that be. Politics prevails, as a means of getting favors, and forces subservience of conscience to convenience.

The efficiency of medical practice is lowered. The doctors know that the hospital is not theirs. They must accept what is offered to them. And they do not feel responsible for the hospital service.

All know of the unfair competition against the private practice of medicine which hospitals knowingly sponsor by giving free treatment to patients who can afford to pay.

Equally well recognized are the extremes by which doctors are taken advantage of in rendering free work, under the excuse of getting experience.

At present, pathologists and roentgenologists are reduced to the status of salaried employees, with almost complete loss of independence. The next step will be to reduce other specialists to the same extent. Then state medicine will predominate over independent practice almost entirely.

Plumbers, business men, and lawyers operate their own shops and offices. Why must doctors be bossed by laymen?

If the medical profession wishes to maintain its independence and individuality, it must cooperate and organize so that it can own and operate its own hospitals.

M.D.
Boston, Massachusetts

Trick TO THE EDITOR: With regard to the question of nurses giving anesthetics ("Anesthesia Beckons," December MEDICAL ECONOMICS)—are they allowed to prescribe drugs of other types? Certainly not.

Isn't an anesthetic a drug and a dangerous one? It most assuredly is.

True, they give other drugs to patients, but they are told by a doctor just how much to give and how often.

On the other hand, consider the surgeon who is busy with an operation. Does he have the opportunity while working to tell a nurse-anesthetist how to administer the anesthetic? He does not.

This argument alone is reason enough why it should be against the law for nurses to give anesthetics.

One trick some hospitals are using is to pay a nurse anesthetist $100 per month and turn all anesthetic fees into the hospital's coffers. Hence, most hospitals using nurse-anesthetists are probably doing so for their own economic good rather than for their patients' welfare.

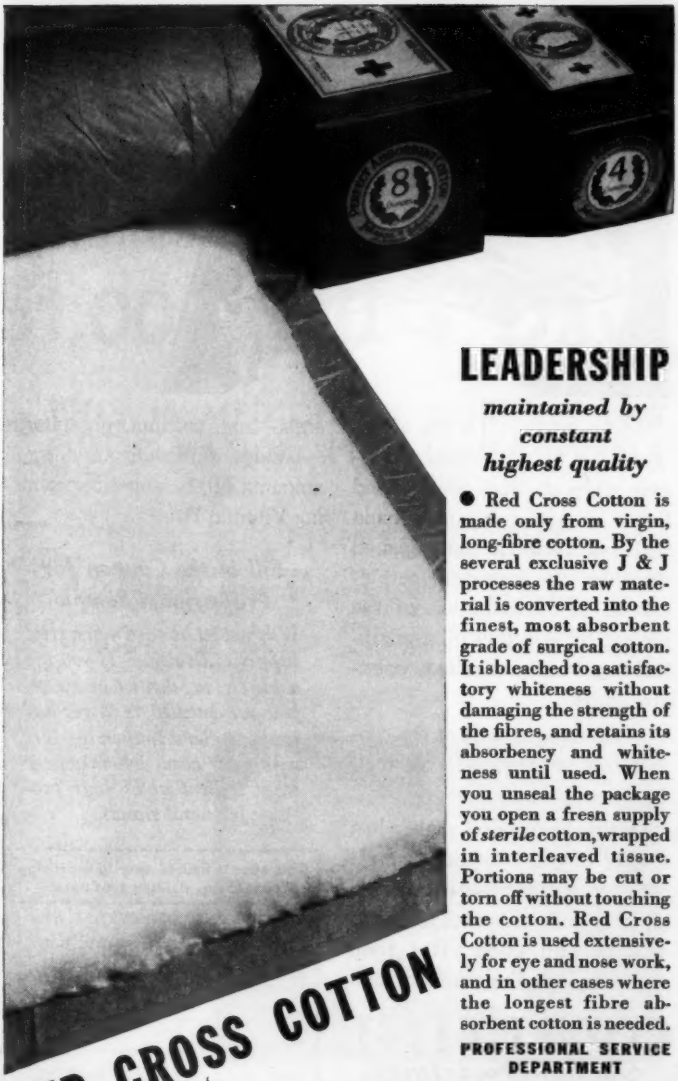
L. E. Thompson, M.D.
Salida, California

Booster TO THE EDITOR: May I express my appreciation of the service being rendered to the medical profession by MEDICAL ECONOMICS? Many of us read it from cover to cover, and look forward each month to the new copy.

It covers a field that is certainly neglected, not only by most of our medical literature, but even by the doctors themselves.

W. H. Geistweit Jr., M.D., Secretary
San Diego County Medical Society
San Diego, California

[*Continued on page* 75]



LEADERSHIP

maintained by constant highest quality

● Red Cross Cotton is made only from virgin, long-fibre cotton. By the several exclusive J & J processes the raw material is converted into the finest, most absorbent grade of surgical cotton. It is bleached to a satisfactory whiteness without damaging the strength of the fibres, and retains its absorbency and whiteness until used. When you unseal the package you open a fresh supply of *sterile* cotton, wrapped in interleaved tissue. Portions may be cut or torn off without touching the cotton. Red Cross Cotton is used extensively for eye and nose work, and in other cases where the longest fibre absorbent cotton is needed.

PROFESSIONAL SERVICE DEPARTMENT

RED CROSS COTTON

Johnson & Johnson
NEW BRUNSWICK, N. J. CHICAGO, ILL.

IN the aftermath of disease, when physical debility and loss of strength run hand in hand with loss of appetite and impaired digestion, the important consideration is rehabilitation of the patient by selection of strength-building, easily digested, palatable foods.

As an integral part of the convalescent or postoperative diet, Ovaltine is ideal.

Ovaltine adds food quality in a readily digested, liquid form. It considerably increases the digestibility of milk, enhances its palatability and adds vital food elements, including essential minerals—iron, calcium, phosphorus—besides furnishing additional amounts of the appetite-producing Vitamin B.

Fill in the Coupon for Professional Sample

Why not let us send you a trial supply of Ovaltine? If you are a physician, dentist or nurse, you are entitled to a regular package. Send coupon together with your card, letterhead, or other indication of your professional standing.

OVALTINE

The Swiss Food-Drink

Manufactured under license in U. S. A. according to original Swiss formula

This offer is limited only to practicing physicians, dentists and nurses

THE WANDER COMPANY
180 No. Michigan Ave.
Chicago, Ill. Dept. M.E. 3

Please send me, without charge, a regular size package of OVALTINE. Evidence of my professional standing is enclosed.

Dr. .....

Address .....

City ..... *State* .....

Canadian subscribers should address coupons to A. Wander, Limited, Elmwood Park, Peterborough, Ont.

MEDICAL ECONOMICS
The Business Magazine of the Medical Profession

To Charity: $1,000,000 a Day!

THIS IS MEDICINE'S GIFT TO THE PUBLIC, NATION-WIDE SURVEY REVEALS

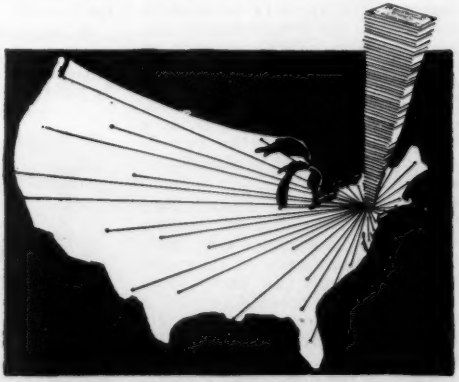
THE machine-gun fire of replies to MEDICAL ECONOMICS' December questionnaire asking "How Much Charity Work Do You Do?" has now reached a total of 5,823 cards.

The returns indicate that the average American doctor contributes 24.58 per cent, or almost one quarter, of his time to medical services for which, under existing conditions, he can expect no compensation.

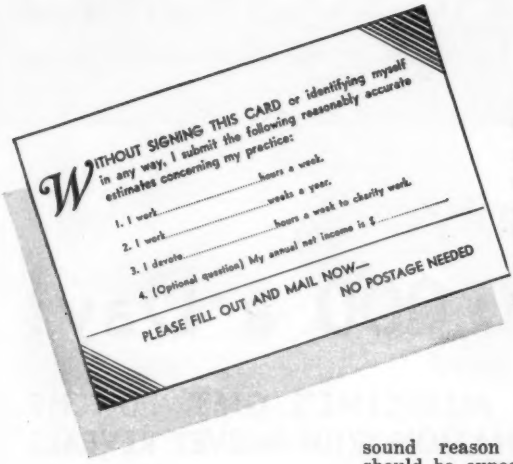
Combine with this the additional one quarter of his time for which he charges but can not collect, and it will be seen that about *one half the doctor's working hours are given over to free work!*

Now since the American medical profession during non-depression years collects a total of more than $750,000,000 annually, it follows that $375,000,000 represents medicine's approximate yearly gift to the public.

This figure, founded on an accurate tabulation of facts supplied by the profession itself, bears out the estimate often ven-



"A total of 5,823 reply cards —from every state in the Union."



Doctors who filled in these questionnaire cards did not sign their names, hence felt no hesitancy about replying candidly.

tured that *American doctors do more than a million dollars' worth of free work a day!*

The MEDICAL ECONOMICS charity survey is notable in that it was not confined to one or two cities. It does not, therefore, give only a sectional picture. On the contrary, the answers received in response to the questionnaire are representative of the country at large. Coming, as they have, from every state in the union, from large cities, moderate-sized towns, and rural sections, they provide a true cross-section of the experience of the medical profession as a whole.

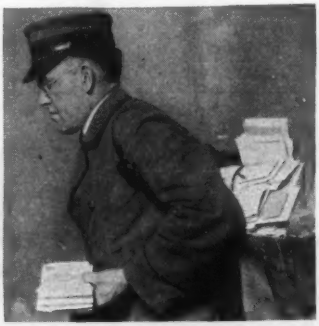
Another factor contributing toward the reliability of the survey is that no attempt was made to secure signatures on the questionnaire cards. In fact, these were purposely worded in such a way that the doctor replying did not have to give his name. He therefore felt no hesitancy in answering the questions completely and candidly.

Returning now to the $1,000,000-a-day figure, is there any sound reason why physicians should be expected to contribute all this money in the form of free work? Do grocers furnish food gratis? Do landlords supply space rent-free?

Not often!

The responsibility for medical charity rests properly with the philanthropic agencies and with our municipal, state, and federal governments—*not with the doctor!*

No physician objects for a moment to the treating of indigent patients. *But he does deserve to be paid for his work!*



All Give And No Take

By SMITH ELY JELLIFFE, M.D.

MOST doctors are "saps," and they know it. They can't help it, nor do they wish to. A sap is, of course, an incorrigible optimist. But without a lot of optimism, this world has little worth while to offer.

After sixty-seven years I am glad I have been and still am a sap. In some quarters I would be called a "poor business man." There is some relationship, I admit, but not much. For nearly everybody is a poor business man.

But this is not what I set out to discuss. I wished to speak of that aspect of our profession's sappiness which is called "charity work," and about which MEDICAL ECONOMICS is publishing statistics in this issue.

Even as a medical student in my first summer vacation, I spent from 2 to 6 p.m. daily in a dispensary in lower New York, mostly lancing felons and applying dressings to old leg ulcers. I recall that once a longshoreman patient gave me a bunch of bananas. He was my most grateful patient.

After graduation I spent eighteen months as an interne. I was boarded and bedded in return for sixteen to twenty hours' daily service. I loved it, especially the bed, after as much as three days and nights of continuous service on the ambulance! I learned thereby one invaluable lesson: Sleepy heads get nowhere, and even 72 hours out of bed can be borne if one is genuinely interested in what he is doing.

I borrowed money to go to Europe to study for a year (poor business man?), but paid it back with interest in three years, protecting the lender meanwhile by a life insurance policy which has paid me over $1,000 in dividends after its twenty yearly payments (good business man?).

[*Continued on page* 139]

"I loved it, especially the bed, after three days and nights of continuous service on the ambulance!"

MIDDLEMEN

By C. RUFUS ROREM, Ph.D.
Associate for Medical Services, the Julius Rosenwald Fund, Chicago

"THE country needs and, unless I mistake its temper, the country *demands* bold, persistent experimentation," President Roosevelt has said.

Certainly such experimentation is definitely the order of the day, as much in evidence in medical practice as elsewhere.

Often stated and attacked from various angles, the chief problem is this: How shall adequate medical care be made available to the masses of people on terms which their pocketbooks can meet, which are economically fair to the physician, and which tend to preserve the essential doctor-patient relationship?

The use of the insurance principle as a means of distributing the unpredictable, uneven, and frequently crushing burden of the costs of medical care is in evidence in several sections of this country.

By means of it a number of people are making provision for possible future health emergencies through the payment of small annual fees. Although many pay in advance, during the year relatively few actually fall in need of the services made available. Thus, from the fund created by the many, those few who do happen to require care in time of illness obtain it at rock-bottom cost.

It must be recorded that physicians as such have had rather little to do with the establishment of most of the earlier insurance plans. Lay organizations, espe-

Not Allowed!

PACIFIC NORTHWEST DOCTORS OFFER SICKNESS INSURANCE "DIRECT TO CONSUMER"

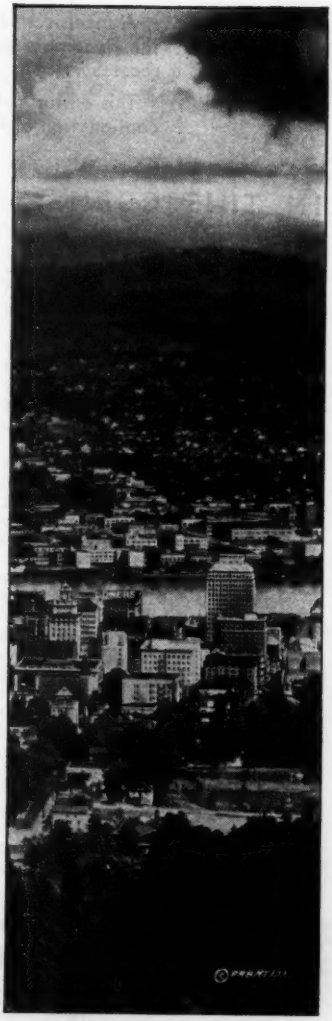
cially hospitals and hospital associations, have been much more ready than they to institute and carry through projects of this kind.

To be sure, they needed the cooperation of the medical profession in order to succeed, and in most instances they have received it. The fact remains, however, that the motivation for these various group plans came from *without*, not from *within*, the ranks of the medical profession.

First winning the active participation of many individual practitioners, these projects have later received full acceptance on the part of local medical organizations. For instance (as reported in the February issue of MEDICAL ECONOMICS), the Medical Society of the District of Columbia has endorsed the aims and methods of group hospitalization as proposed in Washington, D.C. In like manner the Cleveland Academy of Medicine has given its thorough approval to a group plan sponsored by the Cleveland Hospital Association.

In the case of the hospital insurance enterprises, physicians have been cooperating for two reasons: First, they are convinced that these plans make available to subscribers in the lower income brackets a health service far better than that which they could otherwise hope to receive, except as charity. And, second, they believe that any system which re-

[*Continued on page* 103]



Reciprocal Service

A maelstrom of discussion has been stirred up by the December editorial "Shall We Abandon Reciprocal Service?"

This editorial, it will be remembered, favored the continuation of the custom, raising at the same time

IN THIS CORNER, "A.X.Z.," CLEVELAND:

YOUR editorial "Shall We Abandon Reciprocal Service?" hits the well-known nail on the head.

I, for one, agree most heartily with you that physicians should not render bills to one another for services rendered. Any line of reasoning that impels them to do so is hopelessly distorted.

Has the medical code lost its meaning? Has the depression so thoroughly warped our ideals that we are descending to a level where we expect payment from our own brother practitioners?

I doubt seriously whether the profession today can boast the same high esteem of the public that it enjoyed years ago when fees were anywhere from twenty-five cents to a dollar, including the medicine. The abandonment of reciprocal service would place us on an even lower rung of the ladder of public opinion.

For years I have given my services to doctors' families gladly. The thought of compensation never entered my mind. I considered the opportunity of serving them a privilege, and the confidence they reposed in me a compliment.

"If we abandon reciprocal service, Hippocrates will squirm in his grave!"

If I were to receive payment for all this, I suppose my income would mount considerably. Yet I have never encountered a doctor who took advantage of me.

I am told that there are physicians who bill their colleagues for services rendered. I also know that there are doctors who use the ultra-violet lamp for mongolian idiocy. Brothers under the skin!

Is it such a terrific hardship for a roentgenologist to take an X-ray for a colleague or some member of his family? Does a surgeon become hysterical because he has operated on a colleague sans fee? Is a baby stigmatized because he happens to be the child of a physician, and made his debut through the help of an obstetrician who observed professional courtesy? Does a nose and throat specialist strangle on his own tonsils because he swabbed the throat of some doctor's wife without getting a fee?

I doubt it.

A movement toward abolishing the custom of reciprocal or courtesy service is bound to act in the nature of a boomerang. No good can come of it.

The least we can do for one another is to offer our services as a

[*Continued on page* 117]

"Yes!"—and "No!"

the question of whether or not it has become outmoded during the past few years.

That MEDICAL ECONOMICS readers have ironclad convictions regarding courtesy service is clearly attested by the following spirited comments.

IN THIS ONE, "UROLOGIST," NEW YORK:

HERE is my answer to your question, "Shall We Abandon Reciprocal Service?"

Assuming that the doctor requires X-ray examinations, laboratory tests, and similar items which cost real money, is it fair to ask another doctor to dig into his pocket and pay for all this? What return may he expect for the outlay, to say nothing of his expenditure of time and effort?

It has been my experience to be what is called "a doctor's doctor." There is hardly a day when I do not have from one to four or five doctors in my waiting room. They all wish to be treated ahead of paying patients. They all wish to have special appointments which do not conflict with their own office hours. They are difficult to handle, as a class.

And when all is said and done, what is their usual response? Do they send me their consultations? Not a bit of it! They send them to some other fellow, one of my competitors, often for reasons which I need not go into.

Whether courtesy service should ever be given by one doctor to another depends upon the relationship between them. If Dr. Smith has done something for me, if he has sent me a case now and then, if he has shown a personal friendliness at medical meetings, I feel it is proper for me to extend such reciprocal service as I can in the spirit of your editorial.

But when Dr. Jones has been in practice within half a mile of my office, and in all that time has been sending his special cases elsewhere, and not to me, what right has he to my time, my money, and my skill? None whatever. I ask such a man to pay me, and he usually does.

I have treated hundreds of doctors and members of their families in my day, and I have yet to feel that the time and effort were appreciated. If they were, no evidence of the fact has ever reached me.

I pay the doctor who treats my family—if not in real money, at least in a substantial gift, or by sending him cases which he can handle better than I. I would not expect him to work for me for nothing.

Moreover, I find that if I am to be accorded the same quality of treatment that pay-patients receive, I must pay for it. You surely have heard it said over and over again that the doctor gets

[*Continued on page* 116]

"I have yet to feel that the time and effort were appreciated!"

Twelve Months of

AS TOLD TO WENDELL HOLMES

By NORMAN E. CLARKE, M.D.

IN the mind of every doctor whose interest has been intrigued by one of the countless special articles, after dinner speeches, round-table discussions, or private conversations concerning group practice, one or all of the following questions has, at one time or another, arisen to demand an answer.

What about group practice—does the general public approve the idea? Do doctors comprising the group actually maintain their former incomes and decrease their overhead expenses? Is the service rendered equal to that offered by the individual physician? Are patients in sympathy with the graduated fee system wherein one pays more than another for identical service? In short, can group practice be successful?

•

From my own experience in the one year during which the Detroit Polyclinic has been in operation, the answer to every one of the above questions is an unqualified "yes," for the results we have attained in the face of unpredictable difficulties have far exceeded our most optimistic expectations.

If we had set out to prove the futility of group operation, rather than to realize our ambitions, we could not have selected a more suitable place nor a more opportune time than the city of Detroit in the year 1933.

Less than one month after we opened our offices, the two largest national banks in the city and state closed their doors, paralyzing credit and demoralizing industry for a period of two and a half months. Add to this the fact of hospitals operating at less than half their normal capacity, doctors moving from the city because of lack of patients, the increased activities of civic and federal authorities in the provision of free medical care, the slump following the inauguration of the NRA, and you have a nearly perfect proving ground on which to test the merits of group practice.

•

That its principles are fundamentally sound is amply proved, I think, by the fact that in spite of these handicaps, we have been able to carry out every phase of our plans and to answer every one of the foregoing questions to our complete satisfaction.

During the first year our group has cared for more than 3,000 new patients, every one of whom has been rendered a bill commensurate with his ability to pay. Each doctor associated with us has earned an income approximately as large—and in some instances larger—than he did in 1932. Total operating expenses, including rent, have averaged only 32 per cent, in contrast to the usual 40 to 50 per cent for individual physicians.

Collections for the entire year were better than 80 per cent. We have had many favorable comments upon the extent and efficiency of our service, both from patients and from outside doctors. And the graduated fee system—adjusted to the patients' ascer-

Group Practice

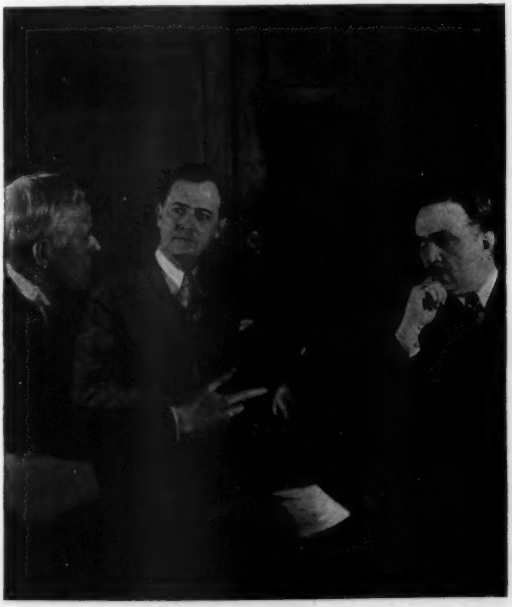
tained ability to pay—has worked with a measure of success that I frankly did not believe possible.

How has all this been accomplished? Simply by applying to the practice of medicine certain tried and tested business principles. As I pointed out in my article in the March, 1933 issue of MEDICAL ECONOMICS, wherein I outlined the preliminary steps we took in organizing the Polyclinic, our ideal was to establish some means whereby the so-called "white collar" class could obtain the highest type of medical care at cost within their reach.

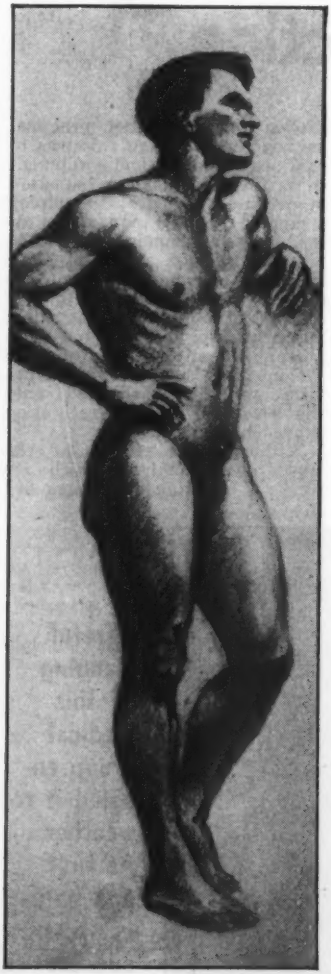
Three years of diligent study and intensive preliminary investigation had brought us to the conclusion that the most practical method for achieving this was to pool our resources and equipment so as to bring about a reduction in overhead expense; to employ a capable business manager to attend to our financial affairs; to provide, through more intensive use of the common X-ray, laboratory and other diagnostic equipment, more thorough medical and dental service; and, most important of all, to inaugurate a system of fees whereby each patient would be charged only the amount which investigation proved he could afford.

Although the results of the 5,000 questionnaires which we

[*Continued on page* 69]



Careful planning by this medical group enabled it to weather its first and hardest year successfully.



Arts and Hobbies On Parade

THE evening of December 20, 1930 saw 600 people milling about the exhibit hall of the Cleveland Academy of Medicine.

It was the occasion of the Academy's first Art and Hobby Show.

Three years later the scene repeated itself, only this time the crowd was even larger, the exhibit still more extensive.

As a matter of fact, so

Pencil drawing by Dr. Gerald S. Sibley, and bronze bust by Dr. Edward E. Woldman.

Photos courtesy Cleveland Plain Dealer

Water-color by Dr. Joseph Wearn.

successful was the original Art and Hobby Show that when the second one was announced not long ago, the officials in charge found themselves laboring under considerable difficulty in the attempt to accommodate local physicians who had volunteered samples of their work for display. So heavy was the response, that they never did catch up with the task of properly cataloguing every one of the exhibits submitted.

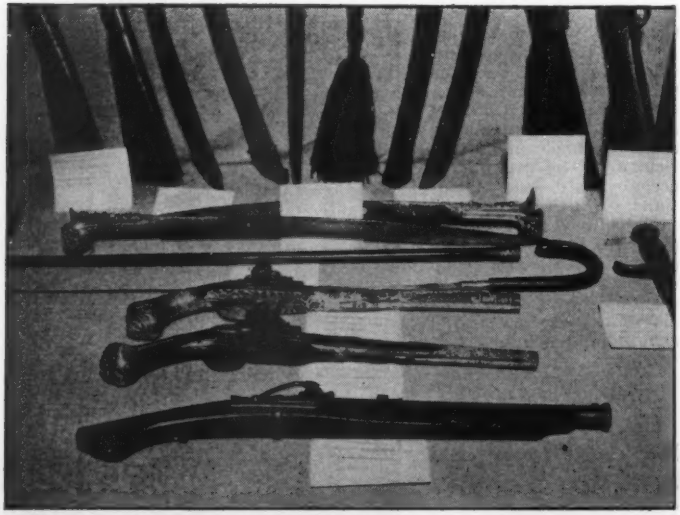
All told, the recent Art

Pen and ink drawing in hand-carved frame, both by Dr. Louis J. Karnosh.

and Hobby Show embraced some sixty-six individually numbered exhibits.

These included oil paintings, water colors, pen portraits, charcoals, chalk sketches; examples of photography, ranging from portraits and actual color photos of orchids to a scientific series showing neuroscopic technique; sculpture; original craftsmanship in fine jewelry; wood carvings; furniture designs; mechanical devices; and a variety of special collections of books, stamps, Osleriana, firearms, swords, and so forth.

Study in modeler's clay by Dr. M. Raymond Kendall.



Old weapons from the collection of Dr. Frank M. Trump.

Both Sides of the Malpractice Muddle

By W. CLIFFORD KLENK

IN any discussion of malpractice, the views of the physician are likely to be tinged with resentment and dread. Resentment because he will have given his best to the patient who proceeds legally against him, and dread because he knows his professional reputation will at least be at stake, if not impaired and possibly destroyed.

He feels, and generally rightly, that any such charge, if he is ever so unfortunate to have one brought against him, will be ridiculous, certainly groundless, and easily disposed of.

This being the essence of his attitude toward the subject, then, it is readily understandable why malpractice insurance should be a source of annoyance to him—something tolerated, paid for grudgingly because he will probably never need it, and in his judgment shamefully expensive considering the amount of risk involved.

•

A study of the experiences of insurance companies granting this form of insurance leads to some highly interesting observations and conclusions. That there is at least a minority in the profession, who feels it is being victimized by the companies is readily evidenced by any survey of opinion, however limited.

This writer only recently propounded a series of questions to a few (28, to be exact) of his acquaintances in the profession, and found that eleven might be classified as definitely opposed, for one reason or another, to malpractice insurance as it is now being offered.

Admitting the obvious limitations of this miniature survey, it at least shows that the dissenting minority welcomes the chance to vent its feelings.

•

Summed up, the "minority" grievances are these: "A few companies have a monopoly on the writing of malpractice insurance... Professional incomes have swooped drastically downward in the last five years, while premium charges have increased ... You cannot get a judgment against a doctor, so the insurance companies are promoting a racket ... Membership in a state or county society is with most companies a prerequisite for malpractice insurance... There are competent physicians who for reasons of their own do not seek and will not accept such affiliations and who are unable in consequence to secure malpractice protection..."

With equal vigor the insurance companies say: "We cannot make money on professional malpractice insurance. We have tried and failed." (They point to the fact that for all practical purposes only three out of some three hundred-odd casualty companies writing various forms of liability insurance will issue malpractice policies.) "The physician is an open target for every disgruntled patient who wishes to evade pay-

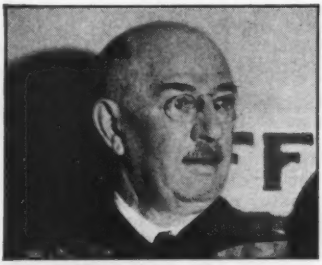
[*Continued on page* 121]

Thunder in

M.D.'S AND SOCIOLOGISTS

ERNEST M. PATTERSON, Ph.D.
President, American Academy of Political and Social Science

HENRY E. SIGERIST, M.D.
Professor of Medical History
Johns Hopkins University



ALFRED STENGEL, M.D.
Professor of Medicine, University of Pa. School of Medicine

THOUGH held in Philadelphia, it was decidedly *not* a Quaker meeting!

Now that it's all over, we might suggest another title for that symposium on February 7 which was staged as a joint conference of the College of Physicians of Philadelphia and the American Academy of Political Science

Various celebrities representing the medical profession and the laity shared the platform in beautiful Irvine Auditorium at the University of Pennsylvania to discuss the socialization of medical care.

"The Medical Profession and the Public: Currents and Counter-Currents" was the general subject of the conference.

"Sociologists and the Medical Profession: Attack and Counter-Attack" describes somewhat more accurately the actual proceedings.

When all was said and done, though several speakers toyed around the fringe of the subject, so to speak, nobody had adequately presented anything approaching a specific program for carrying out the general idea of taking care of all the thousands of persons needing but unable to pay for good medical care.

Early in the day it became painfully apparent that the conference was made up of two openly hostile groups. Divided sharply into the two schools of thought which have obtained since the epochal publication of reports of the Committee on the Costs of Medical Care, conference speakers in a number of instances handled their opposition without gloves.

Aspersion and recrimination, charge and counter-charge fur-

Philadelphia

HOLD STORMY SESSION

nished the highlights of the entire meeting. They were, in fact, too numerous and too sharp to fit in, quite, with one's notion of a proper Quaker holiday.

Indeed, as the day wore on toward the close, a number of Philadelphia physicians were declaring that the conference "seemed to have been stacked against the medical profession."

Certainly Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, had some grounds for feeling that it had been stacked against him personally, his publication, and his organization.

Four of the ten speakers on the all-day program were especially critical of the present organization of medical practice in the United States. They were James H. S. Bossard, Ph.D., professor of sociology at the University of Pennsylvania; Edgar Sydenstricker, director of research for the Milbank Memorial Fund; Michael M. Davis, Ph.D., director of medical services for the Julius Rosenwald Fund; and William Trufant Foster, LL.D., economist.

Dr. Bossard began the skirmish with the opening paper of the conference, "A Sociologist Looks at the Doctors," in which he referred critically to the attitude of many leaders of the medical profession.

"Being well entrenched," he said, "with no difficulties of earning a livelihood, they are reluctant to face any change. They are interested in maintaining the *status quo*.

"The danger is that they may be too arbitrary. This would be unfortunate. If the sociologist's

[*Continued on page* 85]

MICHAEL M. DAVIS, Ph.D.
Director for Medical Services
Julius Rosenwald Fund

ROGER I. LEE, M.D.
Professor of Hygiene
Harvard Medical School

GEORGE P. MULLER, M.D.
Professor of Clinical Surgery
University of Pa. Medical School

Public's Good Will —

A FEW years ago when some Eastern capitalists took over the Dodge Motor Company, considerable interest was shown by the public in a certain item which entered into the transaction.

For the item of good-will, alone, a price of $5,000,000 was paid—$5,000,000 not for real estate, raw materials, finished products, or anything tangible, but for *a good name!*

The new owners of the business, with the same physical equipment and with an equivalent personnel, might conceivably have gone right on producing the same product, without purchasing the previous company's goodwill. But they realized that they would be tremendously handicapped in winning customer-acceptance for their cars unless they could offer them for sale under the original name—one that had already achieved popularity. Thus, for a wholly intangible element —good-will—they were willing to pay the staggering sum asked.

•

If the good name of a solitary manufacturing concern is worth $5,000,000, then, who shall place a value on the good name of the medical profession? Thanks to the high ideals and ethics traditional within its ranks, medicine enjoys the public favor to a degree perhaps approached by no other professional group.

Is this good name not a thing to be safeguarded with the utmost zeal?

Can the backbiting and wrangling among physicians which sometimes occur in the public press, and in lay-read magazines and books ever have any consequence other than to diminish the public's evaluation of the entire profession?

Unfortunately, we have had to swallow

Medicine's Best Asset

far too many pills of this sort lately. Last year, for example, appeared Dr. Roy H. McKay's book "Let's Operate!" which certainly did nothing to elevate the profession among the laity.

There have been other examples. Take that of Dr. Stephen J. Maher, Connecticut's tuberculosis specialist, concerning whose experimental findings the press and certain members of the profession made such a splurge a few months ago.

In describing certain laboratory experiments during which tuberculosis bacilli were said to have been destroyed, Dr. Maher was merely directing the attention of the profession to a line of research which might *some day* result in a cure for the white plague.

But the press, avid for news, screamed to all corners of the country that he was definitely on the trail of a cure for tuberculosis.

To make matters worse, a number of physicians, both individually and collectively, rushed into print, attacking in vitriolic fashion Dr. Maher's reputation as a gentleman and a scientist.

"Don't believe him!" they shouted. "It's a joke. There's nothing new in it. Anyone can kill bacilli in a test-tube!"

The moral of the Maher incident need not be enlarged upon. Suffice it to say that there certainly should be an *esprit de corps* among medical men, a group loyalty, which would make public exhibitions of this sort impossible.

When we attain this end we shall undoubtedly have done both the profession and ourselves as individuals a good turn.

H Sheridan Baketel

Records:

THEY'RE WHAT YOU MAKE THEM

By Edwin F. Patton, M.D.

"JUST how extensive should my system of office records be?"

Rare is the physician who does not find himself puzzled by this problem at some time or other during his career.

Even simple medical cases may require considerable history-taking where certain types of record systems are used. And, for the more complex cases, the amount of paper and ink employed often assumes prodigious proportions.

Yet good records need not require undue labor. Nor do physicians have to sit by helplessly while their offices swell to bursting with filing cabinets and similar paraphernalia.

To be entirely satisfactory, all a record need do is to tell the story of the patient's ailment from beginning to end, giving at each stage of the situation a clean-cut, comprehensive picture of the case.

This is requisite for two purposes:

First, to keep the doctor apprised of everything significant to the case, in order to guide him in its management; and

Second, for the purpose of having on hand all pertinent facts which might be important in case of legal action of any sort later on.

No matter how brief, a record which satisfies these criteria is ample. Any more is superfluous; any less is insufficient.

With these ideas in mind, each physician must install and develop a system which meets the needs of his individual practice. There is no satisfactory method which can be applied to all offices. The doctor's aim should be to satisfy his requirements completely, with a minimum expenditure of time, energy, space, and stationery.

The selection of prepared record-chart forms is likely to be most bewildering to the beginner. He will be confronted with various standardized systems, all worked out in elaborate detail and sold in complete units. Some of these are excellent. Certainly they satisfy the specifications given above.

Their fault, if any, is that they are designed to meet so many different situations that they are likely to be excessive for a given one. Hence they may be wasteful of space and material.

Bane or Blessing?

COMMON-SENSE RECORDS

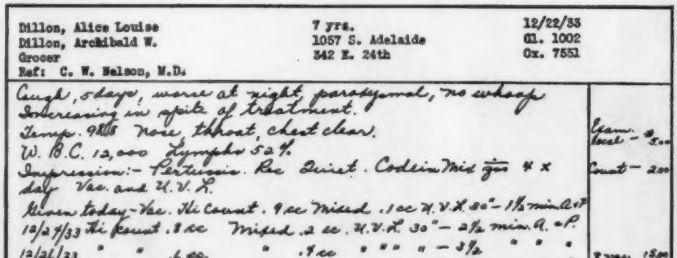
1. For professional efficiency: They must register every piece of information necessary to adequate study and care of the case, at the same time leaving out all non-essentials.
2. For legal protection: They must be carefully dated and worded, picturing conditions at every stage of treatment with utmost accuracy of detail, even to the extent of using figures or small drawings to explain the condition present.
3. For economic purposes: They must contain data to identify the patient personally, professionally, socially, and financially.
4. Entries must be made while the information is fresh—not from memory later on.
5. The best system is that which is simplest and most concise, yet adequate.

Other plans vary all the way from file-folders containing separate form sheets for all the various phases of study and care to single blank cards. All have their useful places, but in making a selection the simplest adequate system should be chosen.

The recent graduate, still mindful of his training in the taking of complete case-histories, feels neglectful if he does not go carefully into family history, previous illnesses, history, travel, and all those things which his teachings have impressed upon him as important.

Yet it is sheer waste of paper and ink to have printed spaces on his forms for all these entries.

As reminders, they may keep him from overlooking something in the history of a rare case. As practical, everyday helps to himself and his patient, their value is slight. [*Continued on page* 81]



When bullets wore no labels. . .Two victims of the gun-fire which swept Havana streets during a revolutionary outbreak, shown here just after the arrival of a physician (dressed in white). This shooting, blamed to snipers, occurred only three blocks from Parque Central.

Scene after a day's fighting. . .Little need for doctors here. This unusual picture was taken outside the Havana morgue following the battle of Atares where more than 200 youths lost their lives and the wounded totaled twice that number.

A Nation Without Doctors

MEDICAL PROFESSION STRIKES IN REVOLUTION-TORN CUBA

By Jack O'Brine

GAY Cuba, they used to call it. And Havana was ballyhooed as little Paris, a city of bright lights and dim ones, the Mecca of tourists from the U. S. A.

Caballeros making it on the Prado, señoritas parading in the Parque Central; these are the sights the tourists remember. Life in Havana was "so colorful, and so very interesting."

But when the color of Havana had turned not long ago to red, the red of revolution and blood, few steamers landed in Cuba, still fewer tourists tramped the streets of Havana. In the World War, there were no more gruesome scenes than those which spattered the once gay Prado during the six revolutions, one for each of the six months beginning last August.

Dr. K. P. A. Taylor, perhaps the best known American physician practicing in Cuba, saw human life become inconsequential before the ambitions of revolutionists. His office, located on the historic Prado, was in the very center of the war zone.

As one of two American members of the National Medical College of Cuba, Dr. Taylor numbers among his patients many prominent families of the Cuban, as well as of the American colony in the tropical capital. He admits,

Terrorist bomb in Medical College... During the revolutionary days in the Cuban capital sporadic shooting was often punctuated by the explosion of a terrorist bomb. This shows the interior of the Medical College building following a terrific blast from which two doctors narrowly escaped.

Closed for the first time in history... The doors of Havana's Municipal Hospital were closed and barred from the inside for the first time in history during the medical strike in January. The strike, which lasted four and a half days, virtually halted medical practice.

(Below) As the fires of revolution burned ..Armed with clubs and burning with an ideal, these Havana students are shown a few minutes before tragedy overtook them. An unexplained outburst of shooting took the lives of four of the number, and ten others were seriously wounded.

though, that neither he nor any other doctor practicing in the island famed for sugar, tobacco, and revolutions has made even a living in recent months.

Collections have been bad. Yes, very bad. Patients able to pay have been afraid to venture out. Medical practice has been confined chiefly to war work: amputations, dressing wounds, and issuing death certificates.

"I saw from my window the bloody chase for 'porristas' which followed the downfall of Machado," says Dr. Taylor. "I saw automobiles draped with nude and mutilated bodies of 'wrong doers.' I saw hand to hand fighting. When a battle is going on in front of a doctor's door there is work to be done.

"During most of the time complete disorganization reigned. And for doctors there were still other difficulties to be coped with.

"Let me be more explicit. Several years ago, there came into being a group of beneficiary societies which, under various names, solicited membership of-

[*Continued on page* 99]

Vitamins should be prescribed in a group

The more medical science discovers about the value and functions of vitamins as they affect the health and well-being of the human race, the more vital these mysterious elements become. A prominent physician has stated:*

"Study of vitamins from a physiologic and therapeutic standpoint has led to the conclusion that the human system cannot survive without the proper intake of vitamins and that it is as important to have a balanced intake of vitamins as it is to have a balanced intake of food supply. No one vitamin, prescribed alone, can give the proper results, but *vitamins must be prescribed in a group,* or at least the mater vitamin A should be prescribed with any other vitamin in order to obtain the proper results."

This confirms the growing conviction that the prescription of any one particular vitamin in excess is more harmful than beneficial, while, as indicated, the intake of a sufficiency of the several vitamins is decidedly beneficial.

Maltine With Cod Liver Oil is widely used because of its known and guaranteed vitamin content. Seventy per cent is Maltine, a concentrated fluid extract of the nourishing elements of malted barley, wheat and oats—rich in vitamins B and G. The remainder is pure, vitamin-tested cod liver oil which supplies vitamins A and D. Taken with orange or tomato juice a fifth vitamin—C, is added. Experience has demonstrated the value of Maltine With Cod Liver Oil in the treatment of metabolisms disturbed by insufficient diet and lack of vitamins.

Maltine With Cod Liver Oil is biologically standardized and guaranteed to contain four vitamins, A, B, D *and* G. Biological report on request. The Maltine Company, *Established* 1875, 30 Vesey Street, New York, N. Y.

**Name on request.*

"Its Efficacy is Practically Nil"

—so writes Sollmann regarding the value of methenamine as a urinary antiseptic *when the urine is alkaline or neutral in reaction.*

But this authority also says "methenamine is by far the most effective urinary antiseptic, provided that the reaction of the urine is acid."

For changing alkaline urine to acid or for increasing the acidity, *ammonium chloride* has been found decidedly more effective than even sodium acid phosphate. It is said that after absorption, the ammonia is converted into urea and the chlor-ion becomes free to neutralize the alkaline bases of body fluids, which otherwise would, when excreted, exert an alkaline influence on the urine: thus the effect is to increase the acidity of the urine (see *Can. Med. Ass'n Jour.*, June 1931).

For obtaining, from full dosage of methenamine, its maximum urinary antiseptic effect, we offer

HEXA-CHLORIDE COMPOUND

the formula of which is presented below. It is a suitably flavored liquid, carefully neutralized during its preparation to insure permanency of the methenamine contained until the product is administered.

Since in many cases of cystitis and other genito-urinary infections, definitely acid urine may cause an undue amount of pain, hyoscyamus, zea mays and triticum are incorporated for their relaxant, sedative and demulcent effects.

Each fluidounce of Hexa-Chloride Compound represents:

Methenamine (hexamethylenamine)	40 grs.
Ammonium Chloride	40 grs.
Tr. Hyoscyamus	40 min.
Zea Mays dry	40 grs.
Triticum	80 grs.
Aromatics	q.s.

The dose is 1 to 2 fluidrams in ½ to 1 glass of water every three hours, if required.

Physicians are invited to use the coupon below to obtain a clinical sample and literature.

PITMAN-MOORE COMPANY

Indianapolis

PITMAN-MOORE CO., Indianapolis M.E. 3, 34

Gentlemen: Please send me literature on Hexa-Chloride Compound and a sample for clinical trial.

.....M.D.

Address .....

City..... State.....

When the Doctor Becomes the Patient

By E. C. DUBOIS, M.D.

RECENTLY I spent three months as a patient in one of the most attractive modern hospitals in the East, in the course of which time I learned a good deal about the patient's point of view.

I expected to be in the hospital about a month and to resume my practice within a period of six weeks from the time I left it. My telephone was covered by our medical service bureau. Appointments were made for the date of my expected return, or patients were referred to other doctors. My insurance companies were informed that I would be incapacitated for a short period, and therefore unable to act as their medical examiner. In other words, it seemed as though the enforced vacation were fairly well planned for, barring the unforeseen.

But the unforeseen was just exactly what did happen. Instead of leaving the hospital at the end of four weeks, I was there fourteen weeks. As week succeeded week and my practice receded more and more dimly into the distance, I was able to appreciate as never before the terrors of a long illness for one whose income ceases the moment he stops working.

I can say with truth that the physical suffering was nothing—hardly existed, in fact—in comparison with the contemplation of facing the future crippled in body, with the task of resusci-

tating the bare skeleton of a practice, if indeed anything were remaining.

Such an experience made me fully cognizant of the impossible burden imposed not only upon the patient but upon the whole family. I realized then what the favored rich and the pampered poor escape in their security from financial disaster, in contrast to the great respectable middle class who find themselves financially crippled for years in their endeavors to meet obligations incurred by illness. Furthermore, it was amply demonstrated by many of my fellow patients that fear and worry are four-wheel brakes to the momentum of one's progress toward recovery.

It seemed to me then, and still does, that we have a responsibility in this matter which we have not been willing to assume.

Of late years, particularly since the start of the financial debacle, there has been increasing resentment against the mounting costs of illness, a resentment which has been vehemently and volubly expressed through many of our popular magazines. We doctors in times past have been the beneficiaries of many kind words, which we hope to have deserved, and the best of unkind ones, which we have been inclined to resent.

•

Nothing is more disturbing to our self-esteem than the attempt to make us the scape-goats of this disquieting condition. We feel that we, too, are victims of a system which has caught us all in its net, and can show that by the increasing extension of charity, the opening of more free clinics, the increasing competition from charlatans of every description, our incomes have also shown shattering reductions at the same time our expenses have been rising.

We tell people that illness is a normal expectation and should be planned for by a system of insurance, and avoided, so far as may be, by periodic examinations. These things are all true and should be brought to the attention of the public repeatedly. But they do not answer the question nor satisfy the complaints.

Sickness *does* cost too much, and it ought not to be left to the exponents of big business or other self-constituted agents to tell us why. It is to our own best interests as well as to those of the patient to consider illness from every standpoint, and stand ready to prune out everything not necessary for the comfort and well-being of the patient.

•

With this object in view, let us give attention to the two high spots of medical costs with the possibilities of their reduction. These are (1) hospitalization and (2) nursing care.

So hospital-minded have we become that we send many patients to the hospital who can be taken care of at home perfectly well. During my "service" as a patient there were cases at the hospital solely for observation, not at all acutely ill—persons who would have gotten along just as well and could have had the same treatment with the same results at home.

We concede immediately that home conditions in some cases are unsuited to the patient's recovery, even when there is no question of costs.

The point is that too many doctors suggest hospital care because it makes their work easier. The fee is just the same, and one has the gratifying feeling of contributing to the support of the hospital (at no expense to himself). No one can deny that the system and order of a well-regulated hospital are a joy compared with the turmoil of the ordinary household, and always to be preferred when one can afford them.

However, unless one's surroundings are impossible or an operation is necessary, the pa-

tient can be taken care of at home. The doctor himself can do all ordinary laboratory tests, and with the aid of a smart, capable part-time nurse he can get the patient back on his feet at a minimum cost, as compared with hospital charges—and with an excellent chance of receiving his fee.

•

Hospital charges for the long illness have become prohibitive. These are directly within the doctor's province. There is no question that even in the best regulated hospitals a great deal of waste goes on, that many economies could be instituted with no reduction in efficiency (particularly as to the weak point of all hospitals, the food).

Even the doctors on the staff are not enough interested in the workings of their hospital. They listen to their patients' complaints and pass them along, not taking them seriously enough to effect a change. I think it may be taken as an axiom that the departments against which concerted criticism is directed are inefficiently and therefore expensively run.

There is no question that during the last few years when appeals for money found a ready ear in the community, we neglected golden opportunities for the support of our hospitals and the partial solution, at least, of medical costs. I refer to the establishment of semi or fully endowed private rooms for the needful case out of the ward class.

There are still people who have some money, even among our own patients, and it ought not to be impossible to interest them in a cause which must appeal to everyone. Such propaganda as this from our own profession would not do us any harm in the eyes of the public. An object more worthy of bequests, or one which would perpetuate the name of the giver more lastingly, would be difficult to find.

The nursing costs come next under our scrutiny. Five dollars and a half a day for the cheapest private room with board and nursing care does not sound exorbitant, nor is it in a well-equipped hospital, for the average three weeks' stay.

Unfortunately, we haven't enough floor nurses to give our patients adequate care. The consequence is that day and night private nurses are necessary for a good share of the time. No doctor needs to be told that $84 a week plus the two nurses' board, plus the minimum of $38.50 for the room are expenses that only a fat bank account can stand, especially when they are prolonged for weeks and weeks and weeks.

I purposely omitted the item of the doctor's fee, because he is quite unlikely to get it. There are a few hospitals in the country which provide sufficient nursing care without the necessity for a private nurse, showing that this very important situation is being recognized and ironed out. The sooner we provide for this in all our hospitals, the sooner shall we approach the solution of our difficulties in respect to hospital costs.

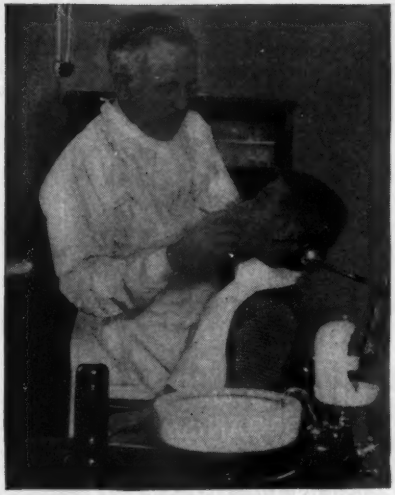
•

In regard to the patient who is treated at home, we all agree that recovery is dependent to a large degree on the character of the nursing. On the other hand, there are very few cases which require a full time graduate nurse for the actual services which she performs. But a practical nurse is no substitute for the quiet, self-contained, surefooted efficiency of the graduate.

We have, however, a satisfactory alternative in the services of the hourly or part-time graduate nurse. I think we are slow in our appreciation of this type of nursing, a type which reduces materially the cost of the patient's care, and at the same time provides the needful service.

She may arrange for a half

[*Continued on page* 129]



A Dentist Works With Me

•

By FRANK HOWARD RICHARDSON, M.D.

IS the average children's man in a position to offer his young patients a *complete* physical examination?

I doubt it.

To be sure, he takes the weight and height, estimates the degree of underweight, and does some other things that the general practitioner is sometimes inclined to overlook. At the same time, he often omits some of the determinations without which it is hardly fair to call his inspection complete.

He does not, as a rule, make any study of the eyes, unless there is such a palpably gross lesion that the mother, the school teacher, or the family friend could not possibly fail to detect it, as in the case of a squint or some acute ocular disease.

He does not, ordinarily, make any hearing test, unless the mother tells him that the teacher has complained of the child's inattention or stupidity.

And as to the condition of the teeth—well, this is beyond the knowledge of most of us. Once in a while we are tempted to guess as to whether an imperiled molar is really a permanent six-year molar or merely a valueless second deciduous molar that will soon come out anyway.

Whichever way we chance it, the dentist to whom we refer the child has an uncanny way of finding us in the wrong!

•

Now if all this is true, the pediatrician is losing one of his main points of vantage, one of the main reasons for his existence as the practitioner of a separate specialty.

A parent brings her child to him so that she may find out what is wrong with him. Perhaps she has already been to several other physicians before she reaches him, in the search for something that is holding the child back from complete health. It behooves him, therefore, to cover the ground as completely as possible if he is to succeed where his predecessors have failed. How can he make sure of doing this?

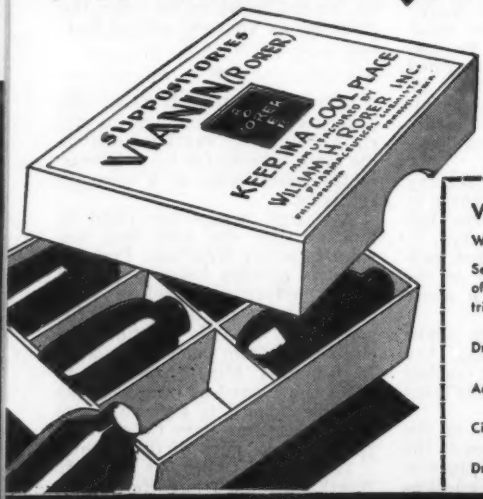
In my own Children's Clinic in North Carolina I have felt espec-

"You Need Be Disturbed No Longer"

CONGESTIVE LEUCORRHEA OF PREGNANCY
LEUCORRHEA DUE TO THRUSH ORGANISM (In children, and in Senile Vaginitis)
NON-SPECIFIC VAGINITIS
CHRONIC CERVICITIS & EROSION OF THE CERVIX

are quickly controlled by

VIANIN (RORER)



Send for a free clinical sample (box of six) VIANIN (RORER) Vaginal Suppositories, with literature and case reports.

VIANIN SUPPOSITORIES

WILLIAM H. RORER, Inc., 265 S. 4th St., Phila.

Send me, without charge or obligation, one box of six RORER VIANIN Suppositories for clinical trial, together with complete literature.

Dr......

Address .....

City..... **State**.....

Druggist .....

WILLIAM H. RORER Inc. Philadelphia Pa.

ESTABLISHED 1010

ially the need of adequate dental service. The majority of the children who come away from their homes to spend their vacation in such a mountain resort as the one where I practice are well when they start.

And although an increasing amount of referred work comes here from year to year, there will probably always be a higher percentage of supposedly well children in this locality than a pediatrician would have in a city practice with its higher proportion of acute illness. Thus, *preventive* dental service some time ago became a real necessity in my practice.

•

How the matter of securing laboratory examinations was made financially possible here, I have told in an earlier article in MEDICAL ECONOMICS. That stopped up one of the largest gaps in the Children's Clinic. Now I am hoping that in time there may be a sufficient volume of work to warrant a similar plan for securing roentgenological examinations.

Though this is as yet rather far in the offing, I have managed recently to settle the question of *dental* service. Suppose I explain how this was done.

I began by asking the cooperation of some of my colleagues in an experiment. If this succeeded, I decided, it ought to supply an additional valuable service. For it would pick up defects not even suspected by family, teacher, or physician.

In order to be a success, the plan must justify itself financially for the dentist who gave his time to it. It must also be of practical value to the patients who took advantage of it.

Last summer seemed a good time to make the trial. We began on rather a small scale. In the course of the first season we found out the possibilities of an eminently satisfying type of work that can be enlarged in subsequent years to a point where it will become one of the major functions of the Clinic.

We have discovered some of the faults of the tentative plan tried out. All these can easily be remedied. I believe that the general principle is one that, with modifications, can be made workable in connection with almost any pediatrics practice.

But to return to the dental plan . . . I began by inviting a dentist to give me part of an afternoon each week, guaranteeing no financial return whatever. I was to furnish the space required, provide any necessary or nursing help, and send the dentist whatever patients I could.

He was to do whatever examining was required of patients sent to him and to make a record of his findings in each case—*without either treating or prescribing.*

The equipment the dentist brought along was of the simplest kind: He had a small electric sterilizer which made it possible for him to practice quite as perfect asepsis here as he could in his own office. He also brought along a small portable engine, which ran from the house current.

Paper cups, paper towels, toothpolishing brushes to fit on the dental engine, cotton packs, and so forth completed his equipment.

•

The Clinic furnished a well-lighted room, with running water, in order that he might do as good work here as possible. There were also a glass-topped table, a high chair, a stand for his sterilizer and his portable engine, and a table on which could be displayed toys for the amusement of the children.

A wall chart, given by one of the dental supply companies, illustrating the time of eruption of the various teeth of both sets, deciduous and permanent, was framed and hung on the wall. Quite as valuable as this was a

[*Continued on page* 131]

Can the Doctor Advertise?

DOES the law allow the individual physician to advertise himself and his services?

The answer, emphatically, is no!

Is it legal, then, for doctors to advertise as a group or profession?

Here the answer, decidedly, is *yes!*

On the whole, the courts have consistently prohibited advertisements of purported "specialists," miraculous "cures," and all forms of self-praising or "come-to-me" advertising. They have done so, obviously, on the grounds that such advertising has a tendency to deceive the credulous and the ignorant, and is therefore harmful to the public health.

Though in various sections of the country the constitutionality of the decisions prohibiting individual doctors from advertising has been called into question in recent months, the situation remains unchanged.

•

Despite the fact that the law remains pretty well settled, not all doctors, it would appear, are sufficiently conversant with the exact status of the law as it applies to them. There seems, in fact, to be an increasing tendency on the part of individual practitioners in some quarters to employ paid solicitors to secure patients for them.

Neighbor Jones, they observe, uses salesmen to go out and interest people in the particular automobile for which he has the agency. Neighbor Smith sends out agents to persuade people not only to buy life insurance but to take out their policies with his company.

Perhaps the custom of these men to employ outside agents is what has given certain doctors the idea that they also may rightfully use salesmanship, or third-person persuasion, to increase their clientele.

This, of course, is *not* the case. In the eyes of the law the doctor is quite a different person from all other purveyors of services or commodities. On this point the courts have spoken specifically:

"The business of the physician directly affects the public health and it does not follow, because the merchant, the manufacturer, and others may solicit trade through hired agents, that a physician may do the same thing. The legislature has forbidden the physician to do so, and there are . . . sound reasons upon which to base the distinction. The law undertakes to protect the physician from the temptation and the patient from the danger to which they would both be exposed by such a practice."

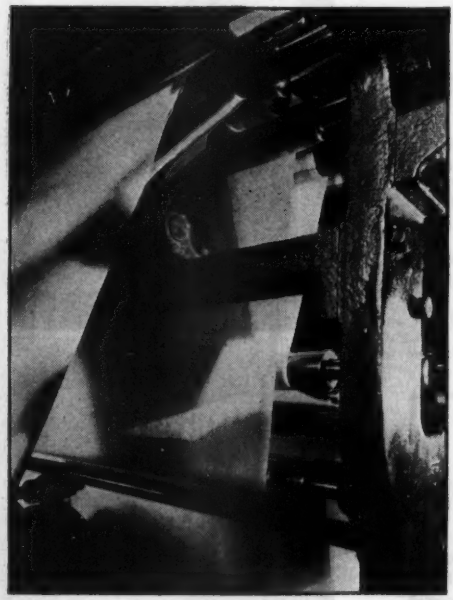
•

The foregoing quotation is from the decision in one of the most famous law cases dealing with the question of medical advertising and the paid soliciting of prospective patients, namely, *Thompson vs. Van Lear.* Decided by the Arkansas Supreme Court more than a quarter of a century ago, this case has set a precedent for many other courts since then.

Briefly, the facts of the Van Lear case are these: In 1903 the legislature of Arkansas passed a law forbidding physicians and

surgeons to solicit patients by paid agents. There was considerable evidence of Van Lear's having violated this law. In subsequent litigation the principal question involved was whether the statute was constitutional.

BY ROSS DUDLEY



Van Lear won in the lower courts, but lost in the higher court. Besides what has already been quoted, the Arkansas Supreme Court said also, in part:

"The main question is whether the state law is valid or not.

"The lower court in a well-written opinion held that it was not a valid law, for the reason that it was an unwarranted interference with the rights of physicians; but we are unable to concur in this conclusion. Under its police power, the state has the right to prohibit things that are hurtful to the comfort, safety, and welfare of society.

"It is now well settled that in the exercise of this power the state may regulate the practice of medicine and surgery . . . The law in question concerns the public health, over which the police power has the fullest sway; for, health being the *sine qua non* of all personal enjoyment, it is not only the right but the duty of the state to pass such laws as may be necessary for the preservation of the health of the people . . .

"It is not likely that a physician would hire an agent to drum up patients for him, only to say to them: 'Go thy way; thou dost not need a physician.' A physician who has secured a patient by means of a hired agent has paid out a certain sum to obtain his patient, and is under a strong temptation to put him through a course of treatment, whether he needs it or not, in order to get his money back and make a profit on his investment.

"Therein lies the danger to the public from such a practice. When a physician obtains patients in that way, he, in effect, buys them, just as if he said to the agent, 'I will pay you a certain sum for every patient you send me.'

"When we consider how easy it would be in many cases for the

PERMANENCY OF RESULTS should be the foundation of judgment in prescribing treatment for skin conditions.

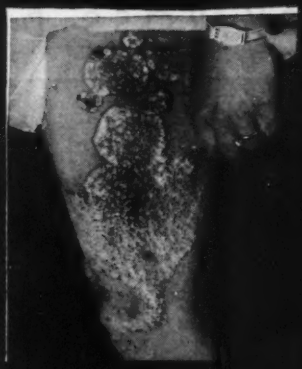
QUALITY of the preparation, rather than the **QUANTITY** employed is a requisite determining factor.

The permanency of results achieved with Mazon together with its distinctive and qualitative characteristics offers an economical local dermal treatment.

DERMAL THERAPY MODERNIZED
COMPLETE RAPID ABSORPTION
IMMEDIATE PRURITIC RELIEF
EASE OF APPLICATION
POSITIVE RESULTS
NO BANDAGING

Mazon is a combination of Phenolic substances and organic mercury compound in an absorbent base.

The increasing popularity of Mazon among physicians would indicate that it might almost be classed as a specific for the treatment of cutaneous lesions.



INDICATIONS:

ECZEMA
PSORIASIS
ALOPECIA
RING WORM
DANDRUFF
ATHLETIC FOOT AND OTHER SKIN DISORDERS

REFUSE SUBSTITUTES

Insist that your patient obtain the original 1-2-4 ounce blue jar.

On Sale at dependable pharmacies. Distributed by reputable wholesale druggists.

PLEASE PRINT

BELMONT LABORATORIES, Inc., ME 36
4430 Chestnut St., Philadelphia, Pa.

Gentlemen: Please send me trial supply of Mazon and Mazon Soap.

Dr. _____

Address _____

City _____ State _____

professional drummer to impose on sick people, and even on those who are well, and induce them to submit to treatment they do not need; when we consider that a physician who has paid for a patient would be under strong temptation to make a profit out of his investment and to give and charge for the treatment whether the patient needed it or not; when we consider the fraud and imposition that would be encouraged by such a method of securing patients—we easily reach the conclusion that the law wisely prohibits a physician from seeking patronage by paid agents."

•

The decision in the *Thompson vs. Van Lear* case has been generously quoted on purpose. For it presents an argument that might well be applied not only to the soliciting of patients by paid agents, but also to certain self-laudatory or "come-to-me" advertising in general by physicians.

Since Van Lear's unsuccessful attempt to set aside the Arkansas law, there have been a number of attacks upon various state statutes regulating advertising by physicians. These have been based, broadly speaking, upon certain basic arguments.

One is that statutes prohibiting advertising by physicians spring from an invalid exercise of the police power. To this the United States Supreme Court has said:

"The police power extends to all great public needs. It may be put forth in aid of what is sanctioned by usage, or held by the prevailing morality or strong and preponderant opinion to be greatly and immediately necessary to public welfare."

Public welfare, obviously would include safety, health, and morals. And as the practice of medicine deals essentially with the health of the public, conduct of physicians or surgeons which might injuriously affect it would seem to be well within the police power.

In the second place, it has been said that statutes prohibiting advertising by physicians constitute class legislation. However, in a notable Tennessee case (*Kirk vs. State*, 150 S.W. 83), a decision followed by many other courts in recent years, the court said:

"We are of the opinion that there is no lawful discrimination in the provision of the statute, and that it is not subject to the objection that it is vicious and arbitrary class legislation."

Again, it has been claimed that preventing advertising by physicians is equivalent to depriving them of their property without due process of law. With this view, too, the majority of courts have clearly expressed disagreement. The statement of the Supreme Court of Washington in *Laughney vs. Maybury* is typical.

"Anyone has the right to pursue any lawful calling; yet, in respect to certain vocations not in themselves unlawful, including the practice of medicine and surgery, the right is necessarily and properly subject to legislative restrictions or regulations founded upon the police power inherent in the state."

Finally, the constitutionality of statutes prohibiting a doctor from advertising has been attacked on the grounds that the statutes are too vague and uncertain in their wording. To this argument also the courts have turned a deaf ear.

•

Statutes which provide against advertising that tends to deceive the public and injure morals or safety, the courts have concluded, are sufficiently definite. It may be left to boards of examiners to determine what specific advertisements come within these provisions. As the court said in the case of *Glass vs. Board of Medical Examiners of California* (195 Pacific 73):

"It would not be possible to frame a definition of unprofessional advertising which would

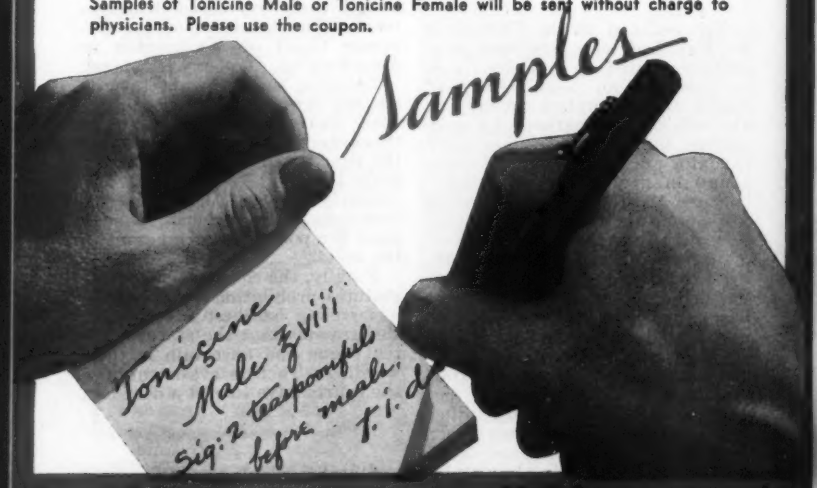
A Reconstructive Gonadal Tonic

Tonicine (MALE) contains, in each fluid dram, hormones representing fresh testicle 25 grains, strychnin sulphate 1/200 grain, and sodium glycerophosphate 1 grain.

Tonicine (FEMALE) contains, in each fluid dram, hormones representing fresh ovary 5 grains, strychnin sulphate 1/200 grain, and sodium glycerophosphate 1 grain.

Tonicine-Male, and Tonicine-Female are indicated in general convalescence, asthenia, anorexia, hypogonadism, and neurasthenia. Tonicine is prepared in two forms to avoid the physiologic error of combining ovary and testicle in the same preparation.

Samples of Tonicine Male or Tonicine Female will be sent without charge to physicians. Please use the coupon.



REED & CARNRICK ME-3
155 Van Wagenen Ave., Jersey City, N. J.

Please send me samples for clinical trial.

☐ Tonicine Male ☐ Tonicine Female

.....M.D.

Address.....

City..... State.....

anticipate in terms every form of advertisement which unscrupulous practitioners might thereafter devise. This being so, it cannot reasonably be held necessary to the validity of the statute that it go further than to state a reasonably definite rule under which all such specific attempts might be included. This, we think, has been done in the terms of statutes so far as the same are now presented for consideration."

•

While no recent decisions have been made with regard to physi-

[*Continued on page* 141]

•

Soothing the patient with music

"Music hath charm to soothe the savage breast, to soften rocks, or to bend a knotted oak." And that's not all.

Dr. A. F. Erdmann, chief anesthetist in the Brooklyn Eye and Ear Hospital, is using music to calm patients being operated on under local anesthesia. He believes it diverts them from the nervous fear which ordinarily taxes their strength and thus delays recovery.

Radio was found unsatisfactory for two reasons: It diverted both surgeon and patient, and even when the use of earphones removed this objection, there still remained the problem of getting the right sort of program for the individual patient.

An electric music reproducer playing phonograph records and fitted with a pair of earphones (earphones which admit enough outside sound so that the patient can hear the surgeon speak to him) has removed both these difficulties. It absorbs the patient's attention better than conversation could. And, being freed of the necessity of talking to his patient, the surgeon is enabled to concentrate all his attention on his operative task.

Contract Practice Under the Yoke

ST. LOUIS MEDICAL SOCIETY FORMS A "CODE AND CONTRACT BOARD"

NEARLY 48 per cent of all actively practicing physicians in the United States, it has been estimated, are engaged in some type of contract practice.

Recent years have witnessed the introduction of underbidding, solicitation, and all manner of abuses in the various types of contract work. Salaries of school physicians have been slashed drastically. Terms upon which insurance examinations, lodge and fraternal work, and other types of contract service are done have in many instances been made steadily less advantageous to the medical profession.

Thus the control and regulation of contract practice has become a problem besetting virtually every county medical society in the country.

What shall be done to improve the situation?...That is a question the St. Louis Medical Society has answered by its Code and Contract Board.

The St. Louis group has gone about correcting the unsatisfactory conditions prevalent in contract medicine in a vigorous and forthright manner.

Their Code and Contract Board, consisting of three members appointed by the president of the society (their terms running for one year, two years, and three years, respectively) is a body with definite and specific disciplinary powers.

It is authorized and directed to investigate any and all written or implied contracts under which any member of the group disposes of his professional services. And

A startlingly new development for creating heat in tissue

The INDUCTOTHERM

● Introduces the most simplified and convenient method ever conceived for the heating of the deep tissues and for fever therapy.

A vacuum tube oscillator, generating an alternating current of 12,000,000 cycles per second. No body electrodes required. Instead a flexible, insulated cable is coiled around that part of the body in which heat is desired.

The magnetic field within the cable produces eddy currents within the tissues and a resulting production of heat.

The inductotherm is destined to augment this form of therapy in every field of medical science.

Write for full particulars.

General Electric X-Ray Corporation

2012 Jackson Blvd. *Branches in Principal Cities* Chicago, Illinois

it is empowered to call any member before it to testify in related matters.

Any member refusing to comply with its reasonable requests must appear before the Committee on Ethics on charges of either non-cooperative or unethical conduct, or both. Upon conviction by the Censors Committee, he shall be suspended from membership for a period determined by the Board.

The Board undertakes to guide the society's members in accordance with the highest ethical principles. Contracts or agreements, whether verbal, written, or implied, are its chief concern, and these it proposes to scrutinize closely for any indication of unethical conduct on the part of St. Louis Medical Society members.

The entering into any such contract, it is particularly provided, shall constitute sufficient grounds for trial on charges of unethical conduct before the Censors Committee if the contract involves:

1. Solicitation of patients, directly or indirectly.
2. Underbidding to assure contracts.
3. Compensation inadequate to assure good medical service.
4. Interference with reasonable competition.
5. Prevention of free choice of physician.
6. Conditions inadequate for proper service to patients.
7. Any provisions or practical results contrary to sound policy.

Members practicing at variance with these principles shall be allowed thirty days (or longer, at the discretion of the Board) in which to present evidence that their practice has been satisfactorily and effectively purged of the objectionable features.

If, after due investigation and advice from the Board, a member persists in objectionable practice and fails to satisfy the Board that he is trying to cooperate with it, charges of unethical conduct are to be preferred against him.

Reference to the Code and Contract Resolution creating the Board (passed as a special order of business at a regular meeting of the St. Louis Medical Society on October 10, 1933) indicates emphatically that this is an organization which proposes to exercise absolute control over its membership, so far as contract practice is concerned. One reads:

"No member of this Society shall make a contract, express or implied, to attend an individual, family, club, lodge, or other organization by the year on any terms other than those authorized by these regulations.

"Institutions making or having contracts not in accordance with the spirit of the policies herein set forth, and which dispose of the services of their staffs without the endorsement of the Board shall not be approved.

"The Code and Contract Board shall annually and from time to time furnish an approved list of hospitals, clinics, and similar institutions for the information of the St. Louis Medical Society. Such institutions shall receive the support and endorsement of the members of the Society.

"Members of the Society serving in institutions not so approved shall not be in good standing if they continue their support, endorsement, or association therewith over ninety days after the institution has failed to win approval.

"The Board shall adopt policies to insure remuneration for services rendered by the profession to institutions supported by public or private funds, taxes, endowments, etc."

•

The regulations adopted, while they permit gratuitous services to the actually indigent or nearly indigent—"those who are incapable of making remuneration without distressing themselves or their families"—place upon the indi-

[*Continued on page* 119]

Which Way Medical Education?

By GEORGE B. LAKE, M.D.

IN the days of our grandfathers, if a young man aspired to become a doctor, he "read medicine" with an established practitioner and, when he was judged to be proficient, he hung out his shingle and went ahead on his own.

One beauty of the arrangement was that, by constant association with a man who was in hourly contact with sick people of all kinds, he learned a lot about the general make-up and peculiarities of the various sexes and ages of the genus *homo* (species almost *sapiens*) so that, when he had to take care of their ailments himself, he had a rather clear idea of what to do.

•

Medical education, today, for better or worse, is something quite different. The men approaching thirty who are graduated from our medical schools are likely to be excellent physiologists, histologists, bacteriologists, roentgenologists or electrocardiologists—but few of them have had the time or opportunity to find out much about being *physicians*.

A visit to one of the Annual Congresses on Medical Education, Licensure, and Hospitals, such as that held in Chicago in February, 1934, coupled with a study of the curricula of the institutions whose teaching staffs were represented there, will give any perspicacious medical man a good idea why that is so.

The rare, lofty, and academic atmosphere feels quite different from that of a sick-room or of a busy doctor's office, perhaps because most of those present are either full-time teachers whose contact with actual patients is a bit sketchy and impersonal, or medical specialists who can not see the great forest of human illness owing to the imminence of the trees of their particular types of specialism.

For years, at these meetings, the same things have been said about the importance of the general practitioner in the medical scheme of things, and about the duty incumbent upon medical faculties of providing him with readily available postgraduate courses that will enable him to keep himself abreast of the times.

Little or nothing seems to have been actually accomplished, however, in encouraging recently qualified physicians to undertake general practice in its real home—the smaller towns and rural districts—or in keeping them on their toes when and if they do locate in such places. The hospital, the big clinic, the laboratory and the office of the specialist-consultant are the ideals most constantly held before them as goals.

It now costs a young man a small fortune and years of hard work to become a Doctor of Medicine, but applicants still continue to seek admission to our medical schools. This they do in numbers far beyond the capacity of these institutions to train them properly, and in spite of the fact that

[*Continued on page* 93]

Many uses for this delicious high-caloric food-drink . . . .

TO THE convalescent—to the expectant or nursing mother—to the active, growing child—Cocomalt is a delicious change from the monotony of milk.

When vitality is at low ebb and appetite lacking—Cocomalt is a valuable adjunct to the diet. It is easily digested, quickly assimilated, *high in caloric value.* It provides *extra* proteins, carbohydrates and minerals (calcium and phosphorus) plus Vitamin D for proper utilization of these essential minerals.

Cocomalt is composed of sucrose, skim milk, selected cocoa, barley malt extract, flavoring and added Vitamin D. Prepared as directed, adds 70% more food energy to a glass or cup of milk.

Cocomalt comes in powder form, delicious HOT or COLD. Packed in ½-lb. and 1-lb. air-tight cans. Also in 5-lb. cans for hospital use.

FREE TO PHYSICIANS:

We will be glad to send you a trial-size can of Cocomalt free. Just mail this coupon with your name and address.

R. B. DAVIS CO., Dept. 35c, Hoboken, N. J.

Please send me a trial-size can of Cocomalt without charge.

Dr. .....

Address .....

City ..... *State* .....

The Doctor and His Investments

By ARNOLD BERNHARD

THE gold standard is the touchstone of monetary faith. If a skeptic wants to know whether his money is "as good as gold," he can, under the gold standard, prove to his own wonder and satisfaction that it really is, simply by marching off to the bank and getting the amount of gold called for on the face of his paper money.

The theory is that the skeptics, who are all of us, will react like the darky who, just prior to the bank panic, drew all his life savings out of the bank. As the teller handed him his three hundred and twenty-three dollars, he asked, "What are you going to do with that money, Uncle Mose?"

"Well, suh," replied Mose, "ah wants to deposit it."

"But you've just withdrawn it," observed the baffled teller.

"Yes, suh, but if ah knows ah kin git it, ah don' want it."

•

This attitude of not wanting your money if you know you can get it is the soul of every modern monetary system. It is the very essence of modern money that the amount of currency and credit built up on the base of a standard—whether that standard be gold, silver, platinum, or anything else of universally recognized value—is greater than the standard itself. Naturally, then, when everybody seeks to convert his paper money and all his bank deposits, insurance policies, etc., into the basic standard, there isn't enough to go around. People get panicky, call loans, withdraw deposits, cash policies, and scramble for what metal there is.

There's your deflation. It is Uncle Mose's theory running in reverse. If you know you can't get it, you want it.

•

Whenever this happens, depend upon it, there will be Senator Thomases to announce that the standard has broken down and that what we need is paper money. The argument implicit in this plausible agitation is that if you offer people what they don't want, they won't want it. That way you discourage the deflation simply by changing the gold standard to a standard of lesser or no universal value.

By so doing, you destroy the touchstone of monetary faith. It does not necessarily follow that you destroy the faith itself. But you're taking an awful chance, because if trust in the purchasing power of money should once begin to crumble, there would then be no good old magic touchstone to restore the faith of the alarmed masses in the value of their currency.

Besides being the touchstone of monetary faith, the gold standard is an important regulator of credit. Under our Federal Reserve law, the required ratio of currency to gold is not more than 2½ to 1. The amount of bank credit (loans and deposits) is limited to about ten times the amount of currency. Thus an ex-

S.M.A. The Antirachitic Breast Milk Adaptation

SO SIMPLE

that even Mrs. .....*can prepare it properly.

SO SIMPLE

that Mrs. .....†will thank you for sparing her much worry and trouble.

(*† No doubt you can supply names from your practice.)

ANYONE CAN FOLLOW THESE SIMPLE INSTRUCTIONS

This proportion remains unchanged. As the infant grows older you merely increase the quantity as with breast milk. (See table below.)

SUGGESTED FEEDING TABLE

Infant	Total Quantity In 24 Hours In Ounces *	No. of Feedings	Quantity per Feeding In Ounces *
2 days	1 to 2½	2 to 3	½ to 1
3 days	2½ to 5	3 to 4	½ to 1½
4 days	5 to 7½	4 to 5	1 to 1½
5 days	7½ to 10	5 to 7	1 to 2
6 days	10 to 12½	5 to 7	1½ to 2½
7 days	12½ to 15	5 to 7	2 to 3
2 weeks	15 to 17½	5 to 7	2 to 3½
4 weeks	17½ to 20	5 to 7	2½ to 4
6 weeks	20 to 22½	5 to 7	3 to 4½
2 months	22½ to 25	5 to 6	3½ to 5
2½ months	25 to 27½	5 to 6	4 to 5½
3 months	27½ to 30	5	5½ to 6
3½ months	30 to 32½	5	6 to 6½
4 months	32½ to 35	5	6½ to 7
5 months	32½ to 37½	5	6½ to 7½
6 months to 1 year	32½ to 40	5 to 4	6½ to 10
6 to 7 Mos..	At this age it is customary to add soups and vegetables to the diet, especially spinach.		

* These quantities refer to fluid ounces of S. M. A. diluted according to directions.

TIME SCHEDULE

7 feedings: 6, 9, 12, 3, 6, 9 and once during night.
6 feedings: 6, 9, 12, 3, 6 and 9 or later.
6 feedings: 6, 10, 2, 6, 10 and 2.
5 feedings: 6, 10, 2, 6 and 10 or later.
5 feedings: 6, 9, 12, 3 and 6 or later.

NUMBER OF FEEDINGS IN 24 HOURS.

The number of feedings in 24 hours should likewise be the same as those allowed breast-fed infants; generally stated not more than seven and not less than five. However, when the infant reaches the age of 6 to 7 months, it is customary to replace one of the feedings with an 8 ounce meal of farina broth soup.

SAVES PHYSICIAN'S TIME TOO

S. M. A. is simple to prescribe. The physician is relieved of exacting detail because he has only to increase the ***amount*** of S. M. A. (as with breast milk) when in his judgment it becomes necessary. The accompanying chart suggests average amounts.

The physician's time is also saved because the chances are good for excellent results under his skilled supervision.

S. M. A. RESEMBLES BREAST MILK

S. M. A. is a food for infants—derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically-tested cod liver oil; with the addition of milk sugar, potassium chloride, and salts; altogether forming ***an antirachitic food.*** When diluted according to directions, it is ***essentially similiar to human milk*** in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physicial properties.

ETHICAL OF COURSE

If babies were all alike, it might not be quite so necessary to have a physician plan and supervise feedings. However, from the very beginning every package of S. M. A. has carried these instructions prominently on the label: ***"Use only on order and under supervision of a licensed physician. He will give you instructions."***

S. M. A. CORPORATION
CLEVELAND, OHIO

S. M. A. PRODUCES RESULTS - MORE SIMPLY, MORE QUICKLY

pansion or contraction of the gold base automatically changes the limit to which the volume of credit may expand.

The reason for all this exposition is to call to your attention that recent monetary legislation has done two things:

(1) It has eliminated the touchstone of gold convertibility.

(2) By reducing the gold weight of the dollar (though even the reduced amount is not available for conversion) it has permitted an almost limitless expansion of credit.

The immediate object is to raise prices. But to raise prices, it is not enough to provide money and credit in superabundance. It is necessary to make the money and credit go to work.

If private initiative is lacking, there are but two ways of making money go to work. The first is to scare it to work. This means currency inflation, or unlimited printing press issue. People are convinced then that the purchasing power of money will decline, so they hasten to spend before prices go still higher. The velocity of turnover under such conditions becomes amusing. In Germany, during the inflation, confirmed bachelors were seen buying baby carriages, dust cloths, school books, anything, just to get rid of their money in a hurry, for the only certainty was that everything would be twice as high within a few hours.

Without the touchstone of convertibility to rekindle faith in the currency, such a panic, once started, could hardly be stopped until the currency had been blown to smithereens. We are not likely to get such inflation in this country, for the present.

In its place, it is more likely that the second means of making money go to work will be tried—that is, credit will be forced into use through public works, public loans, and public subsidies of all sorts.

The first effects of Government spending will probably be felt through the C.W.A. and the A.A.A. These agencies pump money directly into the purses of consumers. By building up public purchasing power and lifting commodity prices at the same time, the government plays directly into the hands of *retail trade.*

This is especially true of mail order houses serving rural territories, because, while C.W.A. expenditures (mostly in the cities) may taper off later this spring, the A.A.A. (farmer benefits) goes on all year round.

•

There is a good deal of *building* to be done. Families that have doubled up, city dwellers heading for small country places, slum clearances, badly run down dwelling places—all these offer a good field for business, if money can be made available. In its search for outlets for its manufactured credit, the government will surely not ignore this opportunity.

Manufacturers of building supplies are laying in heavy inventories even now in anticipation of a boom. The benefits may be revealed a little later than in the case of retail trade, but they appear to be inevitable.

Machinery is a capital investment. To buy machinery, industrialists must have long term loans. Thus far, the uncertain monetary policies have thoroughly squelched all long term financing. The resultant stagnation in the "heavy" industries has probably been the main reason why our recovery has lagged so far behind that of Canada and England.

If we are to recover, money must be forced into capital goods.

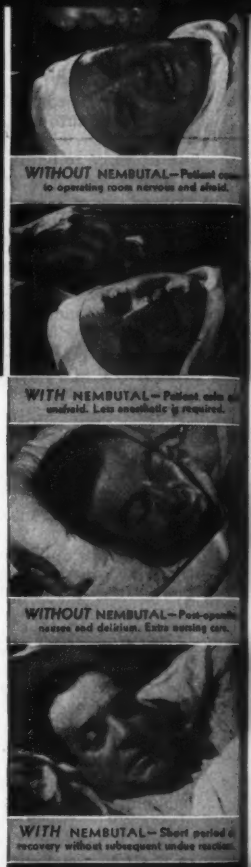
Since the nation's problem is not so much one of greater production as of lower costs of production, the chances are that this money, when it is forthcoming, will go into modern machinery

[*Continued on page* 67]

NEMBUTAL

Produces desired results

WITH ONE-HALF THE DOSAGE OF CERTAIN OTHER BARBITURATES



● Nembutal (Pento-Barbital Sodium, Abbott) is of outstanding value as a pre-surgical sedative. Its profound sedative and short hypnotic action from a dosage only about one-half that required with certain other barbiturates; its rapid effect; the fact that it produces less delirium and restlessness; quick recovery due to the small doses used—all are important advantages. Nembutal is valuable also in minor surgery; in obstetrics, with or without morphine and hyoscine; dentistry; as a quick-acting hypnotic in insomnia; to calm and control nervous, excited and demented patients; and as an anti-spasmodic. Supplied by all prescription pharmacies in ½-gr. and 1½-gr. distinctive yellow capsules. Specify NEMBUTAL, ABBOTT!

FREE

HANDY POCKET PACKAGE FOR EMERGENCY USE

ABBOTT LABORATORIES, North Chicago, Illinois

Send physician's free pocket sample of Nembutal, Abbott, to

_____ M. D.

ADDRESS _____

THE NEWSVANE

Medical Conference Afloat

Six hundred physicians and their wives are to be entertained in March at the home of President Gomez of Venezuela, when the *S. S. Pennsylvania*, sailing from New York on March 14, with the Pan-American Medical Association Congress, arrives at that country.

A number of papers will be read during the sea voyage and there will also be a session in Venezuela, during which several physicians will receive special decorations and be made honorary members of the Venezuela National Academy of Medicine.

During the cruise, which lasts from March 14 to March 30, the physicians will also visit Colon, Cartagena, Puerto Cabello, Caracas, La Guayra, and San Juan, P. R.

High Cost of Quackery

Quacks, quack appliances, and proprietary remedies cost the people of the United States one hundred million dollars annually, declares Mr. Randolph Cantley, of Ridgewood, New Jersey, in a letter to the editor of *The Survey*.

Why, asks Mr. Cantley, must millions of our families pay for medical care without getting it? Why must these revenues be diverted from the hospital clinic to the quack and the medicine-faker?

He then proceeds with the suggestion that the great foundations which have shown so much interest in the cost of medical care ought, logically, to show a similar interest in the high cost of quackery. He suggests, for instance, a fund of a million dollars to advertise directly against fake remedies, and for the purpose of an educational campaign telling people what real medical care is, and where to get it.

"Foundations to the fore!" he cries. "Where can you hope to get more for your money? A million dollars to divert perhaps ten times, perhaps fifty times that amount, from the bandit to the doctor!"

Drug Bootleggers

"In recent years," remarks the *Medical Record* editorially, "a new type of bootlegger has made his appearance. He deals in drugs and pharmaceuticals . . .

"In the good old days of the alcohol bootlegger, many people died when the stuff supplied was not so good. It is hard to estimate the harm the drug bootlegger does. This bootlegger will take a well known pharmaceutical, counterfeit the product as well as the container, and sell his product to the less scrupulous druggists at a lower price, enabling them to make a bigger profit . . .

"The false labels on packages are got in the same way as were those supplied to the bootlegger of alcohol; fake label makers have become highly skillful . . .

"This whole business is a rather vile state of affairs. The physician can do a lot to combat this evil. He knows his druggist,

Mulford Pollen Extracts from Hay Fever Plants *common* in your Community

The popular Graduated Dose Treatment Package in Syringes (also in Vials, if preferred). Compact. Convenient. Only ½ cc. per dose.

THE Pollens Dried and Pollen Extracts prepared by the Mulford Biological Laboratories offer you a "Complete Hay Fever Service"—an extensive assortment of pollens and packages for diagnosis and treatment which thoroughly meet your own requirements in your own community.

Only specific pollens—accurately identified, pure, and botanically true to label—are used in Mulford Pollen Extracts. They are freshly prepared and standardized, and will retain their full strength through the dating period. Clinical tests have established their potency.

To further meet your requirements, our Medical Department will assist you in any problem of pollen allergy which confronts you. Our booklet, "Hay Fever Therapy," mailed on request.

MULFORD BIOLOGICAL LABORATORIES

Philadelphia **Sharp & Dohme** *Baltimore*

and he can make a note on his prescriptions, in order to stamp out this evil, that no substitutions shall be made for the original product prescribed.

"It may seem that the physician by doing this is protecting the pharmaceutical house. He should. The reliable houses do everything they can to maintain a high standard of efficiency and uniformity, and the physician should cooperate. Aside from all this, he is protecting the public against one of the most unscrupulous bands of pirates that ever existed."

Accident Toll

America continues to be a sweet land of sudden death, according to accident statistics for 1933, recently released by the National Safety Council, with headquarters in Chicago.

Last year 89,500 persons were killed in the United States accidentally. Examination of the detailed figures reveals that there is no place like home to break your neck or to receive some other fatal injury. Some 29,500 persons were killed by accidents in the home, almost as many as perished in automobile accidents, namely 30,500.

The total of occupational deaths for the year was 14,500. And, aside from the fatalities, accidents caused 8,500,000 disabling injuries. Financially, the nation's accident bill for 1933 was two billion dollars in wage loss and medical expense.

Soldiers, What Next?

Katherine Mayo, author of *Mother India*, the book which aroused such a furor several years back, has a new volume, an extensive, painstaking investigation of the ex-soldier situation. (*Soldier, What Next?*, Houghton, Mifflin Company, $3.50).

"What becomes of the incredible sums Congress has voted for the veterans at the demand of American Legion lobbyists?" she asks.

Apparently a lot of it goes into the "handsome country clubs" used as soldiers' homes and veterans' hospitals and the "medical" care of their inmates. Concerning them Miss Mayo writes:

"The man with a pension for a missing finger joint who can muster an ailment that some doctor will certify as unfitting him, temporarily, for work, can live in a soldiers' home, be outfitted with all the good new clothes that he seems to want, from overcoat to spats, get his dentistry done for nothing, and be freely given excellent board, lodging, medical care, and entertainment. With the monthly 'temporary total disability' allowance due him as a hospital man, he is soon able to get himself a car, as many do."

Doctors and Taxes

During the depression, fuel and food venders have received payment fairly consistently for what they furnish to the poor, the medical profession has observed. But physicians, it seems, are expected to render their services to the unfortunate ones gratis. Doctors are expected, too, to pay taxes. Why, medical groups are asking, should cities allow some citizens to work out their taxes and water-rent and overlook the doctor? Why not give him credit against these items for the unpaid-for services he renders to the city's dependent poor?

Emergency Treatment Only

Hereafter during the economic depression, staff service in Toledo hospitals is going to be limited to acute emergency operative cases. At least that is the intent of a resolution recently passed by the council of the Toledo Academy of Medicine.

The committee recommends that any physician who does not adhere to the spirit of the decision

be requested to resign from the Academy. At the same time, a pledge to do no more routine, but only emergency surgery in the hospital clinics has been signed almost unanimously by the eye, ear, nose, and throat section of the society.

29-Cent Calls

Eight district physicians recently appeared before Mayor Samuel Sloan of Utica, New York, to request an increase in salary. The mayor told them he did not favor increases in city payroll. However, the city doctors had come well armed with figures to back up their arguments.

When they told him that seven of them had made a total of 608 calls during January for which they had received $262.50, or, deducting the cost of automobile operation, an average of 29 cents per call, he was duly impressed.

In fact, he readily admitted that the doctors had made a good case, and said that he would take up the matter of salary increase with the Estimate Board.

Hospital Graft Clean-Up

The new broom is sweeping clean. Under Mayor La Guardia's administration politics are being banished from New York's city hospitals—all kinds of it, partisan, medical, and office. District leaders no longer dictate appointments; executives holding position by the grace of political parties are out of favor; and numberless abuses have been removed by administrative surgery.

However, the Commissioner of the Department of Hospitals, Dr. S. S. Goldwater, is still learning things about politics as played under the graft-ridden Tammany régime.

A few days after he had been in office he remarked to one of his superintendents of long experience, "It seems to me, Doctor, that these city hospitals exist 50 per cent for the sustenance of the politicians and 50 per cent for the patients. How about it?"

"Your figures are far from exact," the superintendent replied. "Eighty per cent politics and 20 per cent for the patient would be more like it!"

Soviet Health Center

They do things in the grand manner in Soviet Russia. At least, their plans are impressive.

The Soviets, say visiting representatives, are planning a huge new health center of twelve buildings, to be erected on a 200-acre tract at Leningrad, at a cost of $51,500,000.

To be known as the All-Union Institute of Experimental Medicine, the new center is to have facilities for large-scale medical research on the human body and its functions. A unique feature is to be the study of the healthy human being as a basis for research into disease conditions.

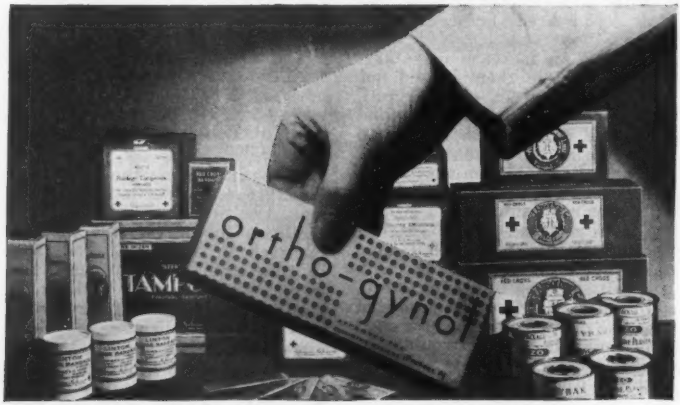
There are to be air-conditioned chambers in which human reactions to every climate in Russia, from the Arctic cold to subtropical heat can be studied, and rooms in which the din and dust of industrial conditions will be faithfully reproduced.

Ground has already been broken for the section to house the personnel of 3,500. The whole project is expected to be completed in from three to three and a half years. There is to be in addition to the institute buildings a residential settlement including modern furnished apartments for 12,000 persons, along with schools, theatres, and clubs.

Negro Health Fund

The power of pennies—provided you have enough of them—is evident in the proposed plan of the Reverend Amos Carnegie, originator of the Negro National Hospital Fund. The Reverend Mr. Carnegie plans to raise, over a

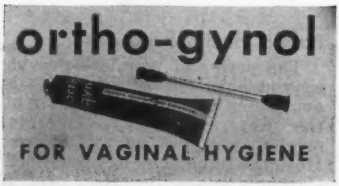
ANOTHER CONTRIBUTION FROM THE Johnson & Johnson LABORATORIES



● Thanks to the endorsement of physicians who have been prescribing it with such gratifying results, Ortho-Gynol now takes a permanent place among the universally known products bearing the Johnson & Johnson signature.

Not until it had received years of clinical study in leading hospitals was Ortho-Gynol introduced to the medical profession as a whole. Its efficacy now has been thoroughly established. Under the guidance of their physicians, hundreds of thousands of women are employing this safe method of vaginal hygiene with entire success. The tenacious vegetable gum base of Ortho-Gynol temporarily closes the cervical canal, entangling and destroying by means of its adequate antiseptic ingredients all motile cells which attempt to enter. Ortho-Gynol is an effective local treatment for Leukorrhea, Vaginitis, and Endocervicitis.

If you have not received a complimentary package containing a full-size tube of Ortho-Gynol and unbreakable transparent applicator, write us on your professional stationery or mail the coupon below.



Johnson & Johnson 11-3

New Brunswick, N. J.

I am a practicing physician. I have not received a package of Ortho-Gynol and descriptive booklet. Please send them.

*Dr.*_____

No request honored except from the profession

twenty-year period, $150,000,000, to be used for the adequate hospitalization of the negro race in America, and for the proper training of negro physicians, nurses, and social workers. The plan is nothing more complicated than this: Each of the 12,000,000 negroes in the United States is to contribute one cent a week to the fund.

Striking But Not True

Inspirational writer, Bruce Barton, has been turning out some copy for World Peaceways, to be published in various magazines free of charge in a campaign against war. In a recent effort the illustration is that of a sick child, a crying mother, and a worried father. "A Hospital Would Save His Life . . . But He Will Have to Die" is the heading, and the copy goes on to say that the child will have to die because "Some of the hospitals are full, others are running part time or not at all, because of the lack of money."

This deplorable state of affairs is explained as being a result of the World War. At the bottom of the page there is another illustration of a bursting shell, with the caption, "The Annual Budget of All Our Hospitals Blown Up, in Powder and Shot, Every 96 Hours!"

Editor Harry Phibbs, of *Hospital Topics and Buyer*, calls attention to this particular piece of copy in order to point out the glaring fallacies therein:

"It is powerful stuff—great propaganda—and when we become fully civilized, no doubt, we will stop blowing up our money in torpedoes and high explosives.

"But the fault we have to find with the advertisement is the insinuation that a child will have to die, or many children will have to die, in America, because they can't get care in a hospital where their lives would be saved.

"While it is true that many of our hospitals are short of money, it is not true that they are running part time. We don't know how a hospital could run part time. It could be half empty, but the part occupied would have to run full time.

"And we don't believe that any such condition exists as that children are dying because the hospitals can't take care of them. Whenever a child is seriously ill and needs hospital care and the parents can't afford it, there is a hospital in the neighborhood which will take the child in as a charity case.

"So all good wishes to Mr. Bruce Barton . . . But next time he brings the hospital into his propaganda, we hope he remembers that, though short of money, we are not letting children in this country die for lack of hospital care."

Low-Cost Clinics

Opened on January 18, 1933 to provide complete medical hospital care for "that large section of the public which is going untreated because of incomes not sufficient to meet the high cost of existing facilities," United Medical Service, Inc., of Chicago, has had a successful first year.

So states its president, Dr. Joseph G. Berkowitz, who claims that the organization, which handled more than 22,000 patients in 1933, made a profit after the first three months of operation. Running costs amounted to $260,000, of which $110,000 was paid in salaries. The organization's original staff of physicians was increased during the year from 21 to 35, Dr. Berkowitz reports.

Perhaps it is worth noting, too, that during the same period the non-professional personnel grew from 15 to 40.

Nurses' 8-Hour Day

Eight consecutive hours in any twenty-four will constitute a legal

day's work for nurses in public hospitals supported in whole or in part by public funds in New York State, if a bill recently introduced before the legislature by Assemblyman Joseph J. Monahan, Kings County Democrat, succeeds in becoming a law.

$300,000,000 for Colds

Two and one-fifth days of work every year are lost by the average employed person in the United States because of common colds, according to a recent study by the American Druggists Syndicate Fellowship.

On the basis of the average wage of $3.50 per day, this means a money loss of approximately $300,000,000 annually. Figuring in an additional loss of $450,000,000 for inefficiency and the cost of medicines and medical care, the total cost is brought up to $750,000,000 a year.

Exodus of Physicians

Since the Nazis have gained control in Germany, according to incomplete statistics, 284 physicians have emigrated from Berlin. Of this number 117 have gone to Palestine, 25 to France, 22 to England, and 30 to non-European countries other than Palestine. The others went to Switzerland, Italy, Spain, Austria, and other countries for the most part, although the destinations of 30 remain unknown.

From other parts of Germany 128 physicians have emigrated, a figure which later returns will probably increase, for approximately 40 other physicians reported to have left Berlin some time during 1933 for another destination in Germany can not be located by the postal authorities.

Low Fees in Roumania

To advertise or not to advertise is no question for physicians and dentists in Roumania. Because of the great overproduction of medical men by the universities, and the cutthroat competition of village witches and quacks of all sorts, according to a recent dispatch from Bucharest, fees are unbelievably low.

The daily press carries professional advertisements regularly. Yet competition is so keen that for ten cents a patient can have a tooth extracted by a qualified dentist, and for twenty cents may consult a physician. Prospective mothers may consult a midwife for a fee of five cents.

All of which would seem to indicate that things are never so bad in one place that they are not worse elsewhere!

Group Plan Popular

Group hospitalization has been introduced into more than 30 cities in 21 states during the last twelve months, according to a recent report by the council of the American Hospital Association. Formal action approving the principle of group insurance for hospital care has been taken by several state and local medical societies, the Association asserts.

Investments

[*Continued from page* 57]

for "rationalizing" present manufacturing plants.

Higher hourly wages and

In These Strained Foods Vitamins Are Highly Retained

Strained vegetables, cooked, strained and vacuum-packed by Heinz, retain high percentage of original vitamin content, and full mineral values.

• The Quality Control Jury of the House of Heinz refused to allow the introduction of Heinz Strained Vegetables until the products conformed with requirements recognized as extremely high.

Impartial tests conducted by a leading institute of research show that in Heinz Strained Vegetables vitamin values are retained to a far higher degree than is possible in vegetables prepared in home kitchens by popularly accepted methods.

ACCEPTED AMERICAN MEDICAL ASSN

Heinz Strained Foods include 8 varieties—Mixed Vegetables, Peas, Green Beans, Tomatoes, Carrots, Spinach, Beets and Prunes

Heinz uses only vegetables grown under strict supervision. Heinz cooks them within a few hours after being harvested. Cooks, strains and vacuum-packs them by methods and equipment designed to reduce vitamin destruction to the practical minimum.

Cooks them in air-tight kettles, by means of dry steam. Strains them, free from air, and seals them into enamel-lined tins.

Heinz welcomes comparative tests by members of the Medical Profession.

May we send you a tin of your choice of Heinz Strained Vegetables? Merely write, on your stationery, to H. J. Heinz Company, Dept. ME 103, Pittsburgh, Pennsylvania.

57

HEINZ Strained Foods

NRA

A Group of the 57 Varieties

higher raw material prices on the one hand, and consumer resistance to price advances in finished goods on the other, will squeeze the manufacturer's profit margin. His defense, of course, will be to install labor saving machinery. The benefits to the machinery industry will be late in showing here, too, but as in the case of building, they appear to be definitely forthcoming.

•

It is the administration's aim in time gradually to leave off forcing credit into industry and permit it to flow naturally through the erstwhile channels of private investment. If it ever should be able to do this—if the "forcing" should succeed in reversing the deflationary cycle—it is difficult to see how under our present monetary laws, the inflation of credit could be checked.

If, on the other hand, credit should fail to inflate in response to government "forcing," the almost certain alternative would be an undeniable political demand for paper money.

Under the circumstances, the least inadequate protection for the investor is probably a substantial commitment in common stocks. Skillful and experienced financiers may do better by playing from second-grade bonds into common stocks. But this is a job that requires expert timing and selection.

•

Twelve Months of Group Practice

[*Continued from page* 19]

sent out prior to the actual formation of the group indicated to us that there was an intense interest among all classes of people in Detroit in ways and means for reducing the costs of medical care, there were some phases of our plans about which we were frankly dubious.

For example, we were somewhat skeptical about the kind of reception our proposed graduated fee system would be given. By some oversight, this point had been overlooked in our preliminary surveys, and not knowing what the exact reaction would be, we feared that patients would become offended when they learned that others were receiving the same service at a lower fee.

But actual experience has proved this not to be the case at all. Most of our patients are wholly in sympathy with our idea

of passing on, in the form of lower fees to persons less able to pay, the economies which combined practice has enabled us to effect.

Briefly, our plan works in this manner: Patients are divided into four groups, namely "A," "B," "C," and "D," in accordance with our investigation of their ability to pay and the amount of service required. The "A" group represents those having a monthly income *per dependent*—not the monthly family income which is apt to be misleading—but a monthly income per dependent of $25 or less. The "B" group has a monthly income per dependent of $30 to $45. In the "C" group are classified those who have a monthly income per dependent of $50 or more. And the "D" group consists of those rare individuals with very large incomes.

The fees for the different groups vary in accordance with the income classifications, the "C" class representing the average charges of the medical profession in Detroit.

But income alone is not the sole factor in determining the classification in which a patient shall be placed. The amount of service required is always taken into consideration, with the result that those requiring considerable attention are often allotted to lower brackets than their actual income would seem to warrant.

The use of this system allows us to determine with utmost fairness the amount patients can afford to pay, and it effectively serves to bring about an actual reduction in the costs of medical care.

While the plan looked hazardous on paper, we determined to try it anyway, and our experience has proved that instead of creating dissension, it has actually inspired confidence. Patients have shown a surprising knowledge and understanding of the factors responsible for high medical fees, and they feel that our plan is a step in the right direction.

Another experience which has been somewhat surprising has been the great number of former patients—many of whom our doctors had not seen for so long as five years—who have come to the Polyclinic for treatment. Reasons for this are varied, but I think the outstanding one is that they feel their reduced incomes will be given a fair appraisal and that they will be charged in accordance with their present ability to pay rather than on the basis of their former wealth.

A third phase of our endeavor which has functioned well is the operating room, which we established for patients who require hospital care but are unable to afford the expense. Patients come to the clinic in the morning, the operation is performed, and they are sent home in an ambulance late in the afternoon.

In the relatively short time we have had this service, the demand

for it has continually increased, and we find that such operations as hemorrhoidectomies, herniotomies, appendectomies, uterine suspensions, ovarian cysts and tumors—in fact, the great bulk of operations which comprise surgical practice, can be successfully performed at great economy to the patient.

To me, these three factors—the success of the graduated fee system, the return of former patients and the popularity of the operating room—represent a significant indication of the great need existing for reduced costs of medical care.

In addition to these illuminating experiences—which, incidentally, are peculiar to our own group and might not show the same results with others—here are several other important aspects of clinic operation which our year of combined practice has taught us. I pass them along for the benefit of those contemplating the formation of a group:

The independence of the doctors comprising the group is a vital consideration for successful cooperative achievement. A man with a dominant personality who sets himself up as "leader" is almost sure to get into trouble. Naturally, there must be someone at the head of an organization to assume responsibility, but that is as much as he can assert himself without disastrous consequences.

•

Group practice should be confined to specialists whose purpose is the reduction of the high costs incident to special medical care and the rendering of the highest type of medical service. Clinical groups, as I view them, are not an attempt to replace the general practitioner. He will always have his place in the realm of medicine. The ideal group supplements the work of the general physician; in no sense does it attempt to displace him.

Our experience has proved to us that outright charity is neither

needful nor desirable. While the variation between the fees paid by our "C" patients and our "A" patients often reaches 75 per cent, that is as far as it goes. We feel that almost every person in need of medical attention can either pay something at the time of receiving it or can make arrangements to pay for it after his health has been restored. We have found that adherence to this policy helps the poorer patients to preserve their self-respect and this, we believe, is as essential a service as curing bodily ills.

Patients should have a definite understanding as to the amount of the fee before any work is done. A frank discussion of the cost of the service inspires confidence and serves to allay the popular fallacy that doctors are out to charge all the traffic will bear.

Bills should be rendered by the group, but they should be itemized to show the names of the various doctors performing service and the amount each one is to receive. This serves to minimize complaints and actually creates goodwill by giving the patient a complete report of the work done.

•

An equitable financial arrangement among the doctors forming the group is imperative, and its set-up should be thoroughly understood by new men joining the organization. We use the percentage system and find it completely satisfactory. When a new man joins us, he makes a sworn affidavit of his previous year's earnings. We add this to the total earned by the other members and then compute the percentage ratio that the newcomer's former income bears to the others. If it is, say, ten percent, he then gets ten percent of the net earnings of the group, payable monthly. We do not ask any man joining our group to make any capital investment other than his equipment, as our building is fully paid for. [*Turn the page*]

When you write for DRYCO the little patient has assurance of automatic protection against rickets without the necessity of additional medication, pleasant or unpleasant. The Dry Milk Company is the *pioneer* in the irradiation of milk—in fact DRYCO is the *only irradiated* dry milk product available. All DRYCO in the hands of druggists is irradiated.

THE DRY MILK COMPANY · INC.

350 Madison Ave. ***Department M.E.*** **New York, N. Y.**

The group should be completely staffed and fully equipped to perform every type of medical service. Our organization is comprised of a general surgeon; an eye specialist; an ear, nose, and throat specialist; a pediatrician-allergist; a dermatologist-roentgenologist; a urologist; two internists; three dentists; four nurses; a dental technician; and a laboratory and X-ray technician. All are highly qualified and each is at all times available for consultation with the others.

Tactful and capable assistants, especially in the business office, are likewise an important consideration to successful achievement. Our office staff includes a business manager, a cashier, a bookkeeper, a switchboard operator and two medical stenographers. Moreover, we employ a full-time collector who also acts as "good will ambassador." Complete facilities for caring for the financial aspects as well as excellent medical service are vital adjuncts to well-rounded clinic operation.

There has been much adverse criticism of group practice in the past. Tradition and prejudice will probably form the basis for more in the future. Like every other new idea which represents an advance over accepted methods, group practice must fight its way through manifold obstacles set up to impede its progress.

Nevertheless, I am wholeheartedly convinced that the medical group will eventually win its rightful place in the realm of modern medicine. It is the best way to combat the ever-constant threat of state and federal control. It affords greater opportunities for the fulfillment of higher type, more efficient medical service. It largely solves the problem of "economic starvation" which today faces so many members of the profession. And it brings to the members of the economically harassed "white collar" class the opportunity to obtain special medical attention at fees in line with their incomes.

Our experience with this form of professional service has proved conclusively to us that it is wholly practical and entirely workable.

Speaking Frankly

[*Continued from page 7*]

Millennium TO THE EDITOR: There are too many doctors. We can't all make a living. So why not ask the Government to remove the surplus as they did with pigs and cotton?

The process is easy: Just ask one third of all the medical men to retire voluntarily, say for five years, the R.F.C. to issue them monthly checks for $250. The doctors to agree not to engage in practice or to fill any other paying occupation, but to spend their time in a glorious vacation, research work, or further postgraduate study at the various American or foreign universities and medical centers.

To accommodate them the medical

schools are to cut down their enrollment of undergraduates, thus eliminating an overproduction of doctors.

And how will the government get enough money to pay for this?

That, also, is simple: Just put a processing tax on every surgical procedure and other medical service. The remaining two thirds of the doctors will have one third again as much business, and will be willing to pay the tax.

This might be made into a fifteen-year plan, so that every five years one third of the doctors will have an opportunity to retire for five years. It should be so successful as to become a permanent code.

M.D.
South Bend, Indiana

P.H.L.A. TO THE EDITOR: In the January issue of MEDICAL ECONOMICS I have noticed the plans for the organization of the Public Health League of America. I think this is a splendid idea and a wonderful help to the medical profession. It is already working well in California.

Hall G. Holder, M.D.
San Diego, California

Entrepreneur TO THE EDITOR: There is a certain slander that has been iterated and reiterated against the medical profession so piously and so continuously that I am almost persuaded that many of our own membership are partial believers. I refer to the accusation that physicians are poor business men.

I believe that possibly I am in a position just now to prove any contention that the real nature of the case is almost diametrically opposite.

Not only has the physician the highest income of any professional man in this country, but he has the highest general average income found in practically any class of human endeavor.

When I read those tables of professional incomes published some time ago by MEDICAL ECONOMICS, I wondered, as perhaps some of you likewise did, where was the good old country doctor who ran a small farm for a living and practiced medicine on the side for the good of humanity?

For the figures quoted in that table, indicating the incomes of the different classes of physicians and specialists, show that there has been a vast change for economic betterment in the past twenty years.

But I believe that I have even better evidence than an array of tabulated statistics to prove my conviction that some of the brightest business minds of the present are now functioning in medicine.

We have heard consistently of the hard-headed and long-visioned business men who have organized our industrial machinery to a smoothness of operation and a prolificness of gain that has been the wonder and the envy of other peoples.

They have taken the profit motive and not only made of it a business and an industrial obligation, but they have raised it in human esteem to the realm of a moral virtue.

Even so, our own profession of medicine has not been far behind in this labor of organization. We too have organizers whose experience it has been to receive exceedingly profitable returns on the money and time they have invested. I could cite examples; but for obvious reasons, I won't.

Though claiming not to criticize, I would like to call attention to what I conceive will be one danger caused by the work of these medical entrepreneurs. That danger is, directly and unequivocably, state medicine.

It does not take a long memory to recall the beginning and development of our present system of state education. And a beautiful analogy can be made between the benefits of state health and of state education—especially when so many public health workers, social workers, and life insurance promoters are all vociferously orating that health is the greatest essential to successful human existence.

Education was once thought to be the panacea for all human ills; and when it became so thoroughly organized that its cost precluded any but the rich enjoying it, state education was the result.

If health—equally essential to human happiness—also becomes so over-organized as to become a monopoly of the rich, what can the answer be but state medicine?

I am afraid that the type of practitioner I have chosen to call the medical entrepreneur, because of the beautiful emoluments resulting from his powers of organization, is going to cause the profession some grief sooner or later. Perhaps the sooner the better.

James A. Norton, M.D.
Conway, South Carolina

Necessity TO THE EDITOR: Hitherto I have been able to cut out articles from MEDICAL ECONOMICS and file them under their respective headings. But when you pub-

COMPETENT MEDICAL AUTHORITIES *endorse* this effective druq

Acetanilid is effective. It relieves pain, especially of nerve origin, for which it is almost specific. It promotes rest by calming nervousness, yet even in large doses is not an intellectual depressant. There is no cerebral depression but the patient is placed in a position to rest calmly. It promptly relieves headache, and can frequently abort a cold. Its action is enhanced by the addition of caffeine and alkaline salts.

MORE IMPORTANT YET: Competent medical authorities endorse the safety of acetanilid. Careful recent tests on animals and patients confirm the fact that the use of acetanilid with and without caffeine, in average therapeutic doses, produces no ill effects. They bear out the opinion of Osborne and Fishbein* that "Acetanilid received a bad name which has clung to it. It does not deserve it."

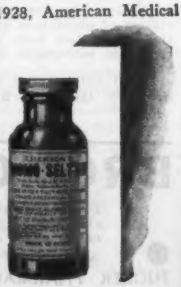
In this second of a series of announcements intended to acquaint the medical profession with recent work bearing on the safety and wide therapeutic value of acetanilid, the Emerson Drug Company takes pleasure in offering you a reprint of a most careful study: "A Study of the Physiological Effect of Acetanilid on Human Subjects," O. Lowy, L. J. Levinson, S. T. Helms, and literature on a series of animal tests (*Journal of Pharmacology & Experimental Therapeutics*, November, 1933).

Bromo-Seltzer is a preparation of known composition containing approximately 3 gr. acetanilid, 1 gr. caffeine with sodium bromide and sodium citrate per dose. It was used in the physiological study cited. A sample will be sent with the literature, *if you request it only.*

**Handbook of Therapy*, Osborne and Fishbein, 8th Edition 1928, American Medical Association, Publisher.

EMERSON DRUG COMPANY, BALTIMORE, MD.
Please send me reprints as specified.

.....
.....
..... M.D.
..... St. & No.
..... City & State



EMERSON DRUG COMPANY
BALTIMORE, MD.

lish five articles in one issue that I must file, the only thing I can do is to save the whole issue.

On the whole, I think it is a good thing for you to know how absolutely necessary MEDICAL ECONOMICS has become.

New York M.D.

Salt TO THE EDITOR: I was exceedingly interested to read "Bills Aren't Necessary" in your valuable issue of MEDICAL ECONOMICS for November. In the Middle West, however, I must confess that we take the author's comments with a grain of salt.

We out here are grossly ignorant, or else the article is so stretched in depicting the possibilities of the medical profession at the present time, that it reads more like a fairy tale than actual existing conditions.

I do not believe that the majority of the people in the Eastern States are any more anxious or better able to pay medical fees in the manner the author describes (unless his clientele is of the élite class) than they are out here. I can not recall more than two occasions in my 25 years of practice when a patient was willing to pay me more than I expected. Certainly, appreciation of medical services at the present time is on the wane.

I am not questioning the doctor's ability to extract cash from his patients under the system he has inaugurated; but it seems that accepting a fee of $300 from a poor man who has not worked for six months and not paid his taxes marks the author as being hardly so philanthropic as he would lead us to assume in the beginning of his article.

I would like to have him try to make any such collection from the farmers in this neck of the woods.

C. G. Moore, M.D.
Fremont, Nebraska

[Conditions vary throughout the country. The underlying idea of "Bills Aren't Necessary" was to point out that some arrangement can usually be made to put some cash (or some commodity) in the doctor's hands immediately. The author does not extract cash; he handles his patients in such a way that they pay voluntarily.

As for getting $300 out of the "poor man," it is to be remembered that in this instance the author asked for no money, and is probably still wondering where the patient got it to pay him.

In short, the objective of the article was to show the doctor how to get some cash, and to emphasize that when approached in the right way the majority of patients will pay to the best of their ability.—Ed.]

Oversight TO THE EDITOR: I would like to express my pleasure in the monthly reading of your publication. As a young physician, I have received invaluable suggestions from the economic subjects discussed by men older in the profession. Some day, I hope, our medical schools will institute courses in the business of medicine that will give us beginners a better insight into what we are up against when we hang out our shingles. I know that I personally was unprepared to undertake the business side of my practice and have wasted valuable years in learning.

Calvin C. F. Boech, M.D.
Montvale, New Jersey

Economics TO THE EDITOR: This is just another one of the flood of letters you must be receiving to thank you for the MEDICAL ECONOMICS Fee Schedule. In publishing this, you have performed a distinctive and greatly appreciated service to the medical profession.

It occurs to me in this connection that another big step in the right direction would have been taken if a national organization of physicians were organized to represent the American medical profession in the matter of medical economics. Let me illustrate why such an organization is badly needed:

On January 8 a meeting was held between the American Hospital Association and the U. S. Employees Compensation Commission, at which time a schedule of fees was agreed upon for the hospital care of injured employees of the CWA. The physicians of the country were not represented at this meeting, however, and no medical organization made any attempt to arrive at a fee schedule for medical services rendered to CWA workers under the U. S. Employees Compensation Commission.

As it is now, the physicians merely send in their statements to the Commission, and the latter cuts these statements to any extent it sees fit.

The foregoing is but one small incident showing how essential it is for physicians to have a national organization to represent them in economic matters. When such a group is formed, I shall be one of the first to join.

L. J. Stauffer, M.D.
Priest River, Idaho

Tamate-Merrell

Represents Recent Work on

Secondary Anemia

The age-old iron therapy in secondary or nutritional anemia has been brought into line with recent experimental and clinical findings.

First, the addition of copper as a "catalyst" and second, the use of a pyrrologenic compound —glutamic acid—have brought about a revision in the therapy of secondary anemia.

Tamate-Merrell combines these three valuable hematopoietic agents in an effective and readily acceptable form, which has been found to step up the blood picture rapidly.

The very pleasant taste, lack of discoloration of the teeth, freedom from gastric upset, render Tamate-Merrell acceptable to young and old alike.

Alycin

Allows Higher Salicylate Dosage

"Push Salicylates" is the byword for the treatment of rheumatism, influenza and associated conditions.

Physicians can readily appreciate the value of obtaining salicylates in a form which, when used in amounts large enough to salicylize, does not cause gastric upsets or other unwanted side-effects.

Alycin combines natural sodium salicylate and a balanced alkali —*natural* salicylate to avoid gastric disturbance, and a balanced alkali to overcome the acidosis that invariably accompanies those conditions for which salicylate is used.

For quick, safe salicylization and prompt effect with a minimum of undesirable side-effects, may we suggest Alycin.

THE WM. S. MERRELL COMPANY

CINCINNATI, U. S. A.

Records

[*Continued from page* 29]

While the occasional case requires thorough clinical study, those in which entries are necessary under the heads of "complete blood count," "urinalysis," "Wassermann," "blood pressure," etc., are the exception. Thus, if a patient comes in with a foreign body in the eye, gonorrhoea, a cold, a sprained back, menstrual irregularity, colic, or any one of the things which constitute the bulk of practice, very few of the spaces provided can be filled. Still, the folder and all the form sheets are there to take up space.

More than one hospital has exhausted its records committee in an attempt to work out suitable forms applicable to all cases, only to abandon them and resort to practically blank sheets of paper, with headings and notes typed or written in to suit the case under treatment.

The same is true of individual physicians. After trying out some of the more elaborate record systems, many have come to the use of simple blank cards.

In the early stages of devising a system, it may be well to employ such a blank-card scheme. Time will soon demonstrate just what heads should be printed if the doctor wishes to utilize printed forms.

For the head of the card, there is no advantage in having printed such labels as "name," "address," "telephone number," "date," "referred by," "chief complaint." All these have to be written down specifically, anyway. Whether or not they are designated in print does not affect their usefulness.

The size of a card or other form used should depend entirely on the type of patients customarily seen. A practice devoted to medical cases obviously would require more extensive notation than one restricted to dermatology, pediatrics, or nose and throat work.

Many physicians have found that little 4" x 6" cards will carry all the information they need. They can be filled on one side, reversed, and then filled on the other if the case continues long enough. An advantage of these small cards is that the active file can be kept in a desk drawer, obviating the necessity for a separate file.

When one card is full, it can be deposited in a separate drawer or filed away. The record may then be continued on a second card, thus avoiding bulky accumulations in the working file, yet preserving reference facts conveniently at hand.

New cards can be numbered in sequence, though dates will serve to keep their continuity correct. Reports coming in from the outside, covering laboratory and X-ray data, operations, consultations, etc., may easily be copied or excerpted, the space otherwise occupied by the separate report sheet thus being saved.

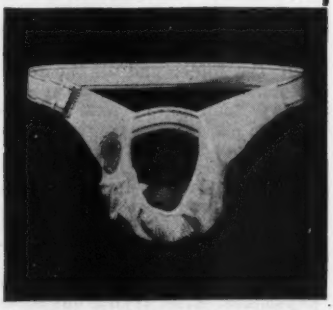
An advantage of the running record on a single card is the fact that the financial account can easily be kept in conjunction with the clinical notes. A vertical space can be ruled off at the right

The profession tells us that these two types of suspensories meet the requirements for practically every suspensory prescription.

THE BAUER & BLACK O·P·C

• The leading double leg-strap suspensory; finest materials and workmanship; elastic waist band and leg straps; comfortable fit. O-P-C No. 2, preferred by most users, $1. Other styles up to $1.50.

THE BAUER & BLACK AUTO



• Constantly increasing volume makes Auto the leading single-strap suspensory; cool, non-chafing, light weight, comfortable; non-elastic waist band, no leg straps. Auto No. 16, extremely popular, 50c. Other styles up to 75c.

• So that you may be more certain that your suspensory prescriptions are filled correctly, we have prepared a completely descriptive Suspensory Guide. It details all the information as to constructions, sizes, materials, workmanship and prices. It should be of help to you when you are explaining to the patient the type of suspensory you are prescribing for him. The Suspensory Guide will be mailed to you, without cost, upon receipt of the coupon or letter of request.

WRITE FOR SUSPENSORY GUIDE
Bauer & Black, 2500 South Dearborn Street, Chicago.
Please send Suspensory Guide. ME-3

Name.....
Address.....
City..... State.....

O • P • C and AUTO Suspensories • made by BAUER & BLACK
Chicago • New York • Toronto
Division of The Kendall Co.

edge of the card, permitting entry of charges for visits, laboratory work, and other services. These fees can be written in at the same time that the record of the services themselves is set down. The up-to-date balance is thereby obtainable at a glance.

For accounting convenience it works well to have two active files: one for paid accounts, the other for open ones.

Whenever service has been given to a patient, the card is slipped into the open-account file. When statement-time comes, the unpaid accounts are thus automatically assembled in one group. As checks come in, payment is recorded; and if settlement is in full, the card is filed in the closed-account division. If a balance remains, the card is put back where it was, so that it receives attention on the subsequent billing date.

An advantage of the small card is that whenever a telephone call comes in the secretary can quickly pull out the card of the caller and place it before the doctor. A glance will serve to remind the latter about the patient's condition at the last visit, as well as about the condition of his outstanding account.

If the doctor keeps his own histories and progress notes in longhand, a 4" x 6" card is convenient. If a typewriter is used by a secretary, a larger card 6" x 8" or 8" x 10" may be found convenient.

It is important for the record card to embrace all the financial and identifying data possible. This will assist in establishing the patient's rating, his dependability as a credit risk, and avenues of tracing if collection proves difficult. Knowledge of the patient's occupational affiliations, family connections, and social contacts is also invaluable at times. Good business would even go so far as to secure the names of references, including the name of the patient's bank.

From the standpoint of good service to the patient, the record should embrace all the historical facts, physical findings, and laboratory data having any bearing on the situation.

•

From the legal standpoint, it is highly important that each entry be *dated*. Also along this line, the physician must train himself when writing and dictating notes to be specific, and accurately delineative—not merely descriptive in a general way.

His previous notes should give him a picture so definite and understandable that he will have no difficulty in comparing past and present conditions in determining progress. For instance, in the care of an elbow fracture where range of motion is slow to return, instead of writing down "better," which means nothing, it is preferable to put down in degrees the actual range of motion, as "flexion limited 15 degrees from normal; extension limited 30 degrees from complete." This means something.

The average doctor will have to expend some effort in order to learn to write such valuable notes, for the majority of those that are written are surprisingly vague and uninformative.

It is good practice sometimes

STRONGLY BUILT

The claims advanced for the Cataplasm-Plus—Numotizine—are strongly built on the experience of thousands of doctors over many years.
This mass evidence proves that Numotizine is a valuable therapeutic agent for the relief of congestion and inflammation.
The kaolin base enables the medicaments—guaiacol and cresote—to be slowly but definitely absorbed through the skin.
Used in respiratory affections and chest colds, it relieves local pain and congestion and helps reduce fever temperature.

THE FORMULA OF NUMOTIZINE IS:

Guaiacol U.S.P.	2.6
Beechwood Creosote	13.02
Methyl Salicylate	2.6
Formalin	2.6
Quinine Sulphate	2.6

C. P. Glycerine and Aluminum Silicate, qs. ad. 1000 parts.

NUMOTIZINE, Inc.
900 North Franklin Street
CHICAGO

NUMOTIZINE, Inc. Dept. M.E. 3
900 North Franklin St.,
Chicago, Ill.

Please send me samples of Numotizine for clinical test.

Dr.....

Address.....

City..... State.....

to get out your old charts and notes, and try to form a mental summary from the jotted words. A few such reviews will teach the doctor how poor many of his notations are, and will help him to improve for the future.

So far as data of a financial nature are concerned, the records should indicate all price-agreements arrived at; all charges for services, no matter how trivial; what bills have been sent out; and what payments have been made. Dates must accompany *all* entries. They are highly important.

By keeping these principles in mind, records—a bane to most of us—can be transformed into a *bona fide* blessing!

Thunder in Philadelphia

[*Continued from page* 25]

study of similar situations of social conflict confers any privilege of making a prediction, it would be this: that entrenched stubbornness can lead only to violent reaction. Perhaps this means that a refusal to socialize medical service is to ride directly into the storm of state medicine."

Mr. Sydenstricker (whose paper was read in his absence by I. S. Falk, Ph.D., formerly associate director of the Committee on the Costs of Medical Care) ridiculed "a leading medical journal" for characterizing the proposals of the majority Committee on the Costs of Medical Care as "socialism and communism—inciting to revolution."

Much more direct was the assault of Dr. Davis, of the Rosenwald Fund, who addressed the assembly on the subject "Change Comes to the Doctor." He particularly resented the fact that while, in his opinion, change was inevitably coming to the profession, it was being noticeably retarded by the reactionary efforts of medical organization leadership.

Various experiments along lines suggested by the Committee on the Costs of Medical Care had been started in a number of communities throughout the country, only to come to naught, he asserted, because of "external pressure brought to bear by the A.M.A." Reporting the remarks of an English commentator on the operation of the English health insurance system, the *Journal A.M.A.*, he said, had printed only those parts which represented the system in an unfavorable light.

"The American people are likely to become impatient with those who do nothing to aid experimentation and have nothing themselves to propose except the philosophy of keeping things as they are," Dr. Davis said, and went on to outline the wants of the intelligent consumer, declaring that he has a right to demand, and is demanding, certain things:

"(1) He wants medical service, not as a charity, but paid for on a basis consistent with the self-respect of American citizens.

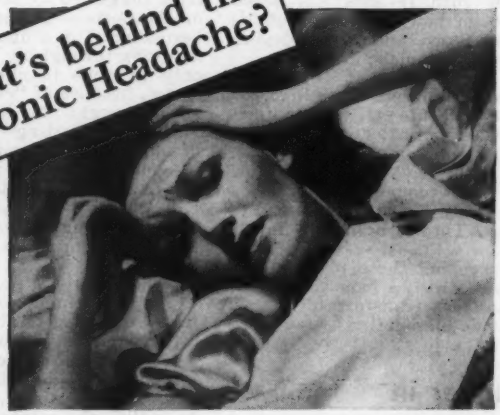
"(2) He wants a medical service which is so organized as to furnish him with continuous contact with a personally interested physician and which does not confuse and subdivide him among a number of independent competing specialists.

"(3) He wants a system for paying for medical service which will develop the maximum paying power from his income and remove the hazard of unexpected sickness bills occurring at the time when his paying power is usually least.

"(4) He wants a system of payment which will stimulate the prevention rather than the care of sickness.

"(5) He wants good hospitals which are available to

What's behind the Chronic Headache?



FEW complaints are more common in the average practice than the chronic headache. And no diagnosis of this condition is more frequent than intestinal toxemia, induced and aggravated by a condition of faulty elimination, often of long standing.

For four decades Sal Hepatica has been the choice of many physicians in such cases. Sal Hepatica is mildly laxative—efficient—palatable. It gently flushes the intestinal tract of toxic waste and corrects the trouble at its source.

May we forward a professional sample? Mail the coupon.

• • •

Fred Allen now on the air in his greatest show . . . the Sal Hepatica Revue. Tune in every Wednesday night, N.B.C. "Red" Coast-to-Coast Network. Don't miss this brilliant show!

• SAL HEPATICA •

MEMO to Bristol-Myers Co., M75 West Street, N. Y. C.

Without charge or obligation on my part kindly send me samples of Sal Hepatica to be used for clinical purposes. (I enclose my card or letterhead).

Name.....*M. D.*

Street.....

City.....*State*.....

him geographically and financially."

Small wonder that by the time he had sat through these talks Dr. Fishbein, next to the last on the list of speakers, should have prepared a special two-page insert for his previously prepared speech. In it he put up a spirited defense, asserting that non-medical groups are attempting to dictate to the physician and the surgeon how to treat patients, that they are seeking to destroy, for selfish motives, the essential individualistic basis of the physician-patient relationship.

Referring to the much-quoted majority report, to which he has registered such pronounced opposition editorially, Dr. Fishbein declared that it had, "except for little gatherings of serious thinkers such as this, lapsed into innocuous desuetude," and that it is "kept alive only by the propaganda which is financially sustained by the Milbank and the Rosenwald Funds."

As for the A.M.A., Dr. Fishbein declared that that organization had "never opposed honest scientific experimentation," and further asserted, "If there is any one fact apparent among all the systems of state and socialized medicine that have been developed throughout the world, it is that not one of them has been established as a success."

William Trufant Foster, economist and writer, who closed the conference with an address entitled "Doctors, Patients, and the Community," was even more blunt in his condemnation of the leaders of the American Medical Association.

"The costs of medical care," he said, "should be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an

individual-fee basis for those who prefer the present method.

"This whole program, however, is bitterly opposed by those unprogressive persons who have acquired control of the American Medical Association. They appear to be a recalcitrant minority of the profession, similar to the obstructive minorities which Mr. Roosevelt has deplored in certain industries. On account of my personal acquaintance, with hundreds of physicians, virtually all of whom repudiate the backwardness, and the politics, and the tactics of the American Medical Association, I can not bring myself to believe that the Association represents the profession.

"This is not a conflict between patients and doctors. It is a conflict between reactionary doctors and progressive doctors. It is merely one phase of the war, now being waged in every profession, between those who imagine that we can still live in an economic age that is gone, and those who realize that we are living in a new economic age . . .

"*The Journal of the American Medical Association* confuses the issue when it says, editorially, 'the right to say how medicine shall be practiced must remain with the medical profession.'

"Nobody proposes that lay boards shall tell surgeons how to operate for cancer, or physicians what to prescribe for pneumonia. Nobody suggests any interference with the science of medicine. On the contrary, the aim is to free the science of medicine from the present chaos of the economics of medicine.

"What the public demands is the right to say, not how medicine shall be practiced, but how it shall be purchased and paid for."

•

The entire conference, of course, did not consist of this sort of thing. One or two of the other speakers wandered briefly into the mêlée. For the most part, however, they were careful to discuss their subjects with a fair degree of dispassion.

Three days after the conference, when the sparks had settled from the fireworks, certain committees of the Philadelphia County Medical Society got together and issued a joint statement attacking "certain sociologists" who, though their ideas were based on "limited information," had been so lavish of derogatory remarks implying "that the medical profession has not been alive to changing conditions."

All said and done, then, this solemn conclave and its aftermath of denials can scarcely be said to have accomplished much. Its principal result was to set loose a flood of newspaper headlines on an already troubled subject: MEDICAL FACTIONS BATTLE AT SESSION, DOCTORS IN CLASH ON MEDICAL RULES, MEDICINE DIVIDES DOCTORS, MEDICAL SOCIETY ATTACKS CRITICS—thereby emphasizing once again the inadvisability of airing cut-and-dried differences of opinion with sociologists and academicians, and inviting the whole world to attend.

Tours & Cruises

CALIFORNIA HANDBOOK: Here is no light leaflet, but a paper-bound guidebook of more than 100 pages, designed to acquaint newcomers to California with most of that widely-advertised state's undoubted charms. This handbook, compact enough to be carried easily in the coat pocket, is really a compendium of useful information about the state, including everything from historical sketches to practical discussions of present-day problems of transportation and living expenses. Upon receipt of your request the International Mercantile Marine Co. (ME 3-34), 1 Broadway, New York, N. Y., will be glad to send you a copy.

●

QUEEN OF BERMUDA AND THE MONARCH OF BERMUDA: These two handsomely lithographed and quite elaborate folders present a convincing impression of the truly royal appointments and accommodations of these superyachts, representing the last word in efficiency, luxury, and comfort afloat. Should you anticipate treating yourself to a trip to Bermuda, write the Furness Bermuda Line (ME 3-34), 34 Whitehall St., New York, N. Y., for copies of these folders, and revel in advance in the sheer luxury and enjoyment they promise.

●

VISIT ROMANTIC GERMANY IN THE OBERAMMERGAU YEAR: Few magnets will draw the American tourist to Europe in 1934 more surely than will the tercentenary celebration of the famous Passion Play. For this year marks the three-hundredth anniversary of the vow taken by the villagers of Oberammergau which brought the Passion Play into being. This illustrated pamphlet, incidentally, points out things of interest to be observed on the way to Oberammergau, and on the return trip. But it is concerned chiefly with the Passion Play itself, with the village, and even more intimately with the simple villager-actors who, generation after generation, have presented "the play with the longest run in history." You will do well to write to the Hamburg-American Line (ME 3-34), 57 Broadway, New York, N. Y., for a copy of this pamphlet if you are thinking of joining the many pilgrims heading this year for the Bavarian Alps.

●

THE NEW FLEET: This is the title of an attractively lithographed folder displaying, by text, by photograph, and by gayly-colored state-room plans four splendid new "Santa" ships of the Grace Line: the **Santa Rosa**, the **Santa Paula**, the **Santa Lucia**, and the **Santa Elena**. Plying between New York and California, these magnificent liners provide an itinerary enroute as fascinatingly foreign as a trip abroad, visiting Havana, Colombia, Panama, El Salvador, Guatemala, and Mexico. Address the Grace Line (ME 3-34), 10 Hanover Square, New York, N. Y., for your copy.

●

MAURETANIA SUNSHINE CRUISES: Is this the year for that long deferred trip to the West Indies and South America? If so, here's a suggestion: The twelve-day cruise of 3,500 miles, including Trinidad, Venezuela, Curacao, Panama, and Cuba seems ideal, as described in this illustrated pamphlet, a copy of which you may obtain by writing the Cunard Line (ME 3-34), 25 Broadway, New York, N. Y.

●

NASSAU-MIAMI-HAVANA ALL-EXPENSE CRUISES: Particularly interesting at this time of the year are the every-week cruises which allow one to get away for an early spring holiday in Bermuda, the Bahamas, or Cuba. This attractive illustrated folder gives all the essential information concerning cruises leaving New York on alternate Fridays and Saturdays. Literature is also available on special tours to Nassau including seven days at a Nassau hotel; also, on two special 8-day cruises abroad the S.S. Pan-America to Bermuda and Nassau. Address the Munson Steamship Lines (ME 3-34), 67 Wall St., New York, N. Y.

●

ALASKA, ATLIN, AND THE YUKON: If the far north holds any attraction for you, you can hardly fail to be entranced by this particular travel booklet. Not only are the photographs numerous and excellent, but the writing is unusually splendid, as colorful and as interesting as any of the better magazine travel articles. For a copy, write the White Pass & Yukon Route (ME 3-34), 2049 Straus Bldg., Chicago, Ill.

●

SAILING REQUIREMENTS AND REGULATIONS FOR EUROPEAN TRAVELERS: Whether you are a seasoned globe-trotter or are contemplating a trip across the Atlantic for the first time, here is a handy guide booklet chock full of valuable information concerning passports, sailing and re-entry permits, visas,

baggage regulations, etc., all of which will greatly add to your peace of mind when you go traveling abroad. A card or letter addressed to the North German Lloyd (ME 3-34), 57 Broadway, New York, N. Y. will bring you your copy of the booklet.

•

WHAT YOU SEE FROM THE TRAIN IN NORWAY: This illustrated, 32-page booklet tells in readable fashion how to get the utmost pleasure and profit from a tour of the Land of the Midnight Sun. It makes no pretense at being a full, comprehensive guide to everything that may be enjoyed along the lines of the Norwegian Government Railway, but it is a handy guidebook which will give you a considerable amount of information about the railways of Norway and the various cities and districts served by them. For your copy, write the Norwegian Government Railways (ME 3-34), 115 Broad St., New York, N. Y.

•

Which Way Education?

[*Continued from page* 53]

the medical field is rapidly becoming saturated, if it is not already so, as some seriously believe.

Views expressed last month by speakers at the Annual Congress on Medical Education, Licensure, and Hospitals would certainly seem to bear out this conclusion.

For example, according to Father A. M. Schwitalla, of St. Louis, president of the Catholic Hospital Association of America, 16,000 applied during 1932 for admission to the medical schools of the United States and Canada. Of these 6,200 were accepted, despite the fact that the ranks of the profession are reduced, by death and retirement, to the extent of less than 3,000 each year.

•

What becomes of the 10,000 who, on this basis, are rejected? It appears that a considerable number of them go to foreign medical schools, to return a few years later bearing important-looking diplomas and demanding admission to our overcrowded ranks.

In 1931-1932 there were 1,482 such students: 308 in Canada; 257 in Scotland; 214 in Switzerland; 188 in Austria; 183 in Germany; and 155 in Italy; with 177 divided among the other countries, including one each in Czechoslovakia, Japan, Mexico, Poland, and the Union of South Africa.

The glut of physicians is especially keenly felt in the larger centers of population, where too many remain in the hope (usually unrealized) of attaining fame or fortune, or both. There are, however, a good many who agree with President Robert G. Sproul, of the University of California, that, if our doctors were so *distributed* that all who need medical service could receive it, we

might find that we would need *more* of them, rather than less.

It is beginning to be realized today that character, personality, energy, and enthusiasm are just as important factors for success in medical practice as is the intellectual ability to pass examinations—perhaps more so. But how can we formulate mass standards of eligibility on this basis, and who will apply them? Personal associations and fat purses are potent arguments!

As to the requisite qualifications for a license to practice medicine, Dr. Schwitalla feels that the members of our state licensing boards should be men of the highest class and capability (they are not always so now). Dr. Sproul thinks that the standards for admission to medical schools should be stricter. Dr. E. P. Lyon, of Minneapolis, says that the public mind must be disabused of the erroneous idea that everyone has a right to those things (such as a medical education) for which the public pays more than half.

Dr. John R. Neal, of Springfield, Ill., declares that, even in states which reciprocate on medical licenses, a *clinical* examination should be given, and that while a national *examining* board is a good thing, the *licensing* of physicians should remain in the hands of the states.

Dr. Dean Lewis of Baltimore opines that the economic morass in which we are now floundering has done more to re-establish the status of the general practitioner than has all the altruistic verbiage of the past decade. Talk in the lobby during last month's Congress amplified this opinion to the effect that the American medical profession today consists almost exclusively of general practitioners.

Many of the hitherto exclusive specialists are treating any sort of patients they can get and even *visiting patients in their homes!* There was a tale, too, about a gynecologist who was doing ton-

sillectomies in the back office!

Dr. James B. Herrick of Chicago does not like the term, "general practitioner," because it connotes a type of medical man which is in process of going the way of the auk and the dodo, and will be satisfactorily replaced by the *family medical adviser*—a man of character, energy, innate personality, deep knowledge of medicine, surgery, *and preventive medicine*. He will be able to handle most of his patients by himself, but will know his limitations and realize when and whom to call when he is out of his depth. He will practice the *art of medicine*, learned from that best of all textbooks, the patient—alive or dead.

Dr. Nathan B. Van Etten of New York emphasizes the importance of having *physicians* control medical education, hospitals, clinics, and conditions of practice. This sounds reasonable when one realizes what meager results (for the medical man) have accrued from the present, largely non-medical, control of these matters.

A tidy little squabble developed at the Congress between Dr. Henry Houghton, director of the University of Chicago Clinic, who told how nice they are, and Dr. Austin A. Hayden, president of the Chicago Medical Society, who raised the rarely-heard voice of a private practitioner in that august assemblage and told how Dr. Houghton's clinics are competing with their own graduates and nearly ruining the physicians on Chicago's South Side.

Dean Cutter, of Northwestern University Medical School, added a few well-chosen words about how *they* conduct clinics and declared that great endowed institutions tend to subvert the outlook of the students who attend them.

There was evidenced at the Congress a good deal of interest about what would be done regarding the status of specialists; but these discussions were not carried out in the open meetings and official statements are not available. Various conversations in the lobbies, however, lead me to believe that what follows is substantially correct in its general import, though it may be inexact in some details:

It seems that the ophthalmologists, otorhinolaryngologists, dermatologists, obstetricians and gynecologists already have societies which pass, more or less unofficially, upon the qualifications of those who aspire to practice these specialties. Plans are on foot to develop similar societies with similar functions in regard to pediatrics, roentgenology, orthopedics, and perhaps some other specialties.

The big new idea which seems to be germinating has to do with

SEED, SOIL and SUNSHINE

Start the job of making Gerber products "BETTER for BABY!"

With scrupulous care the best of seeds are selected. They're planted in the rich, fertile soil of sunny Michigan fields. The soil is further enriched with the necessary minerals and other elements for proper development of the plants. Through every stage of germination and growth they're cultivated and tended with strictest care. Then, at the precise moment of their ripe perfection they're harvested and rushed in covered trucks to Gerber plants. Processing begins at just the right stage of perfection.

Crisp, ripe, freshest of vegetables are the only kind that go into Gerber products. That's one important reason why so many mothers and doctors agree that Gerber's are "Better for Baby."

In fact, only vegetables grown and picked in one's own garden and served immediately can possibly be as fresh as those used in Gerber's. But home preparation lacks, of course, the specially designed equipment that preserves natural vitamin and mineral-salt values during the Gerber scientific cooking and straining processes.

Protection at the source is just one of the steps in the Gerber process which enable us to say that no baby can be served better foods than Gerber's Strained Vegetables and Cereal.

Gerber's

9 STRAINED FOODS FOR BABY

Strained Tomatoes . . . Green Beans . . . Beets . . . Vegetable Soup Carrots . . . Prunes . . . Peas Spinach . . . 4½-oz. cans. *Strained* Cereal . . . 10¼-oz. cans . . . 15c

GERBER PRODUCTS COMPANY, Fremont, Mich. (*In Canada*: Fine Foods of Canada, Ltd., Windsor, Ont.)

Please send me
- ☐ Reprint of the article, "The Nutritive Value of Strained Vegetables in Infant Feeding."
- ☐ Sample can of Gerber's Strained Cereal.

ME 3

Name..... *Address*.....

City..... *State*.....

a *joint board*, composed of one representative from each of the specialistic societies; one from the Federation of State Medical Examining Boards; one from the Association of American Medical Colleges; and one from the Council on Medical Education of the A.M.A. The last-named group is withholding its approval of the project, for reasons which each may imagine for himself.

This joint board would be merely a clearing house for credentials of would-be specialists. Such men would be examined as to their professional fitness by their respective societies and certified to the board, whose action, if favorable, would result in the candidates being listed, officially, under their various specialties, in the A.M.A. Directory. At present, such listings in that ponderous tome are based upon each physician's own estimate of his specialistic status.

Of course this joint board has no legal existence at present, being merely in process of organization, but it sounds as if it might hold possibilities of one sort and another, provided the powers permit it to function.

A year ago the Council of the American Hospital Association and its trustees gave their approval to certain plans for voluntary hospital insurance and group hospitalization. These ideas seem to be spreading and gaining acceptance here and there. The claim is made that the plan is now in operation in thirty cities, located in twenty-one states. What the outcome will be for the rank and file of physicians, nobody knows.

The whole medical cosmos (along with everything else) is in a state of flux, as it has, perhaps, never been before. It is exciting—and somewhat appalling—to watch what is going on.

Undoubtedly, the soundest word of warning so far expressed is that every physician should clarify his ideas as much as he is able and express them with freedom and zeal. Every other interest seems to be intensely and persistently vocal; why not the medical man also?

And, again, why not get together, in smaller or larger groups, and really *do something* coordinated and, if possible, sensible, about conditions which are being forced upon the general profession by outsiders or by those who appear to be more interested in personal prestige or academic notions than in the general welfare?

Certain groups of physicians have already organized to get results. Others are following suit.

Direction-posts are not lacking!

A Nation Without Doctors

[*Continued from page* 32]

fering medical care through clinics which they had established. For a matter of two dollars a month a member was entitled to full medical attendance, including operations and after-treatments.

"Thousands of persons throughout Cuba jumped at the bargain, and for the next few years the Spanish Regional Societies, as they were called, competed with

independent physicians who were forced to cut fees in order to battle for existence.

"During this state of affairs the National Medical Federation of Cuba was organized, and an open war was declared on the regional societies. Doctors belonging to the federation banded themselves into groups of from three to a dozen and established 'mutual' clinics, putting themselves in direct competition with the Spanish beneficiary bodies. However, physicians who chose to remain independent found themselves caught between the two forces.

"It was a survival of the fittest.

"The federation swore that until the Spanish societies were abolished every method possible would be used to divert business from their clinics. The Spanish societies in turn put up a battle, though their position was slightly weakened.

"Independent physicians meanwhile found it increasingly difficult to find patients.

"The leaders of the federation played their ace when Dr. Ramon Grau San Martin, himself a member of the federation, was suddenly swept into the presidency to head a revolutionary government. They lost no time in presenting their case to the new president. Before many weeks had passed Dr. Grau San Martin signed a decree compelling all practicing physicians in Cuba to join the federation, or the 'National Medical College,' as they renamed it.

"This decree radically changed the outlook of the local profession.

"First, with all doctors forced to belong to the Medical College, those who refused were outlawed from the profession. Secondly, those who refused to join were mostly physicians on the staffs of the long-fought Spanish Regional Clinics. So, with the members of

independent physicians who were forced to cut fees in order to battle for existence.

"During this state of affairs the National Medical Federation of Cuba was organized, and an open war was declared on the regional societies. Doctors belonging to the federation banded themselves into groups of from three to a dozen and established 'mutual' clinics, putting themselves in direct competition with the Spanish beneficiary bodies. However, physicians who chose to remain independent found themselves caught between the two forces.

"It was a survival of the fittest.

"The federation swore that until the Spanish societies were abolished every method possible would be used to divert business from their clinics. The Spanish societies in turn put up a battle, though their position was slightly weakened.

"Independent physicians meanwhile found it increasingly difficult to find patients.

"The leaders of the federation played their ace when Dr. Ramon Grau San Martin, himself a member of the federation, was suddenly swept into the presidency to head a revolutionary government. They lost no time in presenting their case to the new president. Before many weeks had passed Dr. Grau San Martin signed a decree compelling all practicing physicians in Cuba to join the federation, or the 'National Medical College,' as they renamed it.

"This decree radically changed the outlook of the local profession.

"First, with all doctors forced to belong to the Medical College, those who refused were outlawed from the profession. Secondly, those who refused to join were mostly physicians on the staffs of the long-fought Spanish Regional Clinics. So, with the members of

the Medical College in the driver's seat, the Spanish Clinics were forced to close down.

"As Dr. Grau San Martin continued in power the influence of the medical college grew. But with his sudden resignation from the presidency in the middle of January, and the ascension of Colonel Carlos Mendieta, the leaders of the college were faced with the loss of all the ground which they had gained. It was this situation, I believe, which led to the sad medical strike—a strike which virtually paralyzed the profession for four and a half days.

"If you remember, everyone in Cuba at that time appeared to be in a striking mood, agitated constantly by leftists and frequently by communists. I was never notified directly of the medical strike, although I was a member of the Medical College. Nevertheless, the movement had not proceeded far until I felt it directly.

"Revolution-like, it spread rapidly throughout the island. All clinics and hospitals were ordered closed; all pharmacies suddenly stood padlocked; threats were rife; and practicing physicians, for the most part, remained at home.

"During the various periods of revolution which have followed the fall of Machado, I have had to face mobs and bullet-swept streets in order to carry on my practice. All the same, in the face of the sinister threats which accompanied the medical strike, I am frank to admit that many days I was uneasy and many nights I could not sleep.

"At the height of the strike more than 25,000 persons affiliated with the Medical College ceased work. You can perhaps imagine the human suffering which this caused."

•

During the four and a half days of the medical strike patients were summarily ousted from hospitals and clinics; babies came in-

to the world on trolley cars, buses, and street corners; surgical operations were postponed; prescriptions were pigeon-holed. Some of the wounded are said to have bled to death, and for lack of medical certificates more than 100 bodies were refused burial and allowed to rot in the city morgue.

Medical strikes have now been outlawed by the Cuban government but the black picture described is none the less clearly imprinted upon the minds of those who witnessed it. In fact, coupled with other slightly less heartening pictures of revolutionary days, the medical strike is bound to remain fixed for many years in the memory gallery of those who practice medicine in Cuba.

Middlemen Not Allowed!

[*Continued from page* 15]

moves from patients, or from those financially responsible for them, the burden of a hospital bill improves the chances of the attending physicians' being remunerated for their services.

However, to fall in line with plans that have been lay-conceived and, to a considerable extent, lay-managed and lay-controlled, is one thing. But for organized medicine to dispense with the equivalent of a middleman and, on its own initiative, to go directly to the consumer of medical services with "service bureaus" furnishing care to large groups of persons under annual payment agreements is quite another thing.

Yet that is just what the medical societies have been doing in certain communities in the Pacific Northwest, where the whole population prides itself upon its progressiveness.

Medical societies in other parts of the country, it is true, have been giving attention to the idea of sickness insurance adminis-

BiSoDoL *in Winter Dyspepsia*

The tendency to overeat, overindulge and underexercise during Winter is no doubt responsible for a seasonal increase of digestive troubles. Patients who complain of indigestion with sour stomach, "acid mouth" and other familiar symptoms, demand quick relief.

In association with your corrective regimen, may we suggest the use of the balanced, antacid-digestant, BiSoDoL to give quick, safe relief.

The combined action of magnesium carbonate with sodium bicarbonate and bismuth subnitrate affords quick neutralization of excess acid without tending to set up an alkalosis. Antiflatulents and flavorings provide additional aid in combating acid indigestion.

BiSoDoL in Common Colds

When you wish to build "alkali resistance," the balanced formula of BiSoDoL enables you to give massive doses at frequent intervals.

Send for samples and literature.

BiSoDoL

The BiSoDoL Company
130 Bristol St. New Haven, Conn.

tered by groups of physicians, but for the most part the matter seems not to have gone beyond the talk-and-print, or theory, stage.

The Northwest, however, has emerged into action. Within the past few years several large groups of physicians in Washington and Oregon have offered their services to employed persons through annual agreements. Free choice of doctor from among participating groups of from 30 to 300 physicians is provided for. And a complete service is offered, covering medical, hospital, and nursing care both for injuries covered by Workmen's Compensation Acts and for ordinary sickness not connected with employment.

In Washington the state medical society is sponsoring the movement, administered through special bureaus established by the local county medical societies. Each medical service bureau is authorized to make agreements to provide designated medical care to groups of employed persons. This includes medical services and hospital and nursing care.

On a recent trip to the Northwest I had an opportunity of studying at first hand the set-up and operation of four of these "medical service bureaus." Those I visited were located in Portland, Oregon, and in Tacoma, Yakima, and Seattle, Washington.

In each instance the bureau is a non-profit corporation, directed by a board of trustees, designated in Washington by the county medical society. The administrative problems of the organization are turned over to a group of directors selected by the trustees. To supervise the professional service rendered, a physician is appointed as medical director. A combination business-manager and sales-director is chosen to run the office and establish agreements with employers and employed groups.

The original working capital comes from the initial membership fees of the physicians. Each fee represents the purchase price of one share of stock in the bureau. Dependent on the other sources of funds which may be available in the community, these membership fees range from as little as $5 to as much as $100.

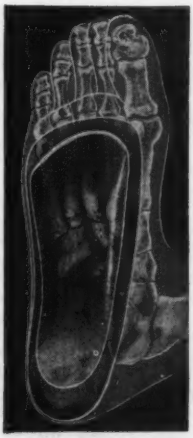
Each participating physician enters into an agreement with the bureau by which he authorizes the organization to offer his services to employed groups, agreeing to accept payment for services on the basis of a given fee schedule, such services to be paid for either in full or on a proportionate basis.

At Tacoma the Pierce County Industrial Medical Bureau, organized several years ago, is operated by the Pierce County Medical Society. During the fall of 1933, it had 2,500 subscribers, with approximately 100 partici-

Proper Mechanical Treatment for WEAKENED METATARSAL ARCH

The two predominating symptoms of Weakened Metatarsal Arch are Metatarsalgia and Callouses on the sole over the Metatarsal region. This condition is easily recognized by the depression of the Transverse Arch anteriorly or at the base of the Metatarsal bones.

The dome-like arching is obliterated and painful callosities or corns form over the depressed Metatarsal heads. The foot broadens, the toes become dorsal flexed. Bunions appear at the First and Fifth Metatarso-Phalangeal articulations. Digital nerves become impinged and severe cramp-like pains are experienced through the toes. This is known as Morton's Toe. These conditions are quickly relieved and the cause effectively corrected with



X-Ray Showing Position of Supporting Plate and Leather to bones of the Arch and Foot.

Dr Scholl's ARCH SUPPORTS

These appliances are especially designed and constructed to restore the Anterior Arch, remove abnormal pressure and permit full freedom of motion to the entire foot. There is a different type to meet each individual requirement.

Shoe or department stores featuring Dr. Scholl's Foot Comfort Service can offer you the ethical cooperation of trained experts in the fitting and adjustment of Dr. Scholl's Appliances. This service is also available through Dr. Scholl's Foot Comfort Shops located in principal cities.

Dr. Scholl's Arch Fitter insures accurate fitting and adjustment as foot condition improves.

THE SCHOLL MFG. CO., Inc.
213 W. Schiller St., Chicago 62 W. 14th St., New York

pating physicians. The Yakima County Medical Bureau offers the services of 30 members of the county society to its more than 2,000 subscribers.

Formed in February 1933, the Multnomah Industrial Health Association of Portland serves 1,200 subscribers through 168 participating physicians. An even more recent plan, the King County Medical Service Bureau in Seattle, established late in the summer of 1933, has enrolled 7,500 employed persons to whom it offers free choice from among more than 300 practitioners.

•

Similar to each other basically, these four plans of course have their individual features. Portland, for instance, limits membership to those whose incomes do not exceed $1,800 per year. The Seattle plan specifies that employees may be enrolled in minimum groups of six.

The rate of monthly or annual payments varies with the individual plan, and with the scope of benefits offered. The usual charge to subscribers runs from $1 to $2 per month. Services offered vary from full coverage to the care of acute conditions only.

At the time of sickness the patient may, for general services, choose any physician on the list of participating practitioners. He is under the exclusive care of the physician whom he first consults. In emergency cases naturally, any physician on the list is eligible to handle the service temporarily.

The bureau is responsible for determining the identity of a subscriber applying for service. No special certification is required for proceeding with treatment, except that a practitioner is expected to report to the bureau immediately when a patient applies for treatment, and when the treatment has been completed.

The attending physician submits vouchers and statements of

Blame MR. POPONDROPULAS!

MR. POPONDROPULAS runs the hole-in-the-wall fruit and vegetable store on the corner. His sunny disposition wins business from many a mother in the neighborhood . . .

Who then blames her baby's *bad disposition* for mealtime "cussedness."

But *you* know that Mr. Popondropulas' fruits and vegetables may have been lying in the bins for days on end . . . may have grown flat, tasteless. And what Mother thinks is bad disposition in her baby—may well be a bad taste in Mr. Popondropulas' green goods!

That is why many doctors suggest Clapp's Baby Food in place of home-strained vegetables. They know Clapp's is consistently high in flavor. For Clapp's Baby Food is made of the finest selected vegetables and fruits, picked at the peak of flavor. Then prepared scientifically to retain the maximum of goodness that Nature put into them. That is why many babies' "dispositions" take a turn for the better when they're fed Clapp's Baby Food.

NOW 15¢
In The New Enamel Purity Pack

15 VARIETIES
The World's Largest Baby Menu

Baby Soup (Strained) . . Baby Soup (Unstrained) . . Vegetable Soup . . Beef Broth . . Wheatheart Cereal . . Spinach . . Carrots . . Peas . . Asparagus . . Tomatoes . . Beets . . Wax Beans . . Prune Pulp . . Apricot Pulp . . Apple Sauce.

Made fresh. Prepared with the most modern scientific equipment and care. Always uniform. Always with the same smooth, proper consistency.

Send for free comprehensive new booklet of recent findings on Infant Feeding. Address Harold H. Clapp, Inc., Dept. 82, 1328 University Avenue, Rochester, N. Y.

CLAPP'S
Original
Baby Soups and Vegetables

the cost of the medical services rendered for each individual case, summarizing them in a monthly statement submitted to the bureau. This statement is studied by a medical audit committee which determines, within limits, the suitability of the treatment given.

Services of a specialist can be had only upon the recommendation of the general practitioner first consulted by the patient. In most instances attention by specialists and certain types of X-ray examination and treatment are handled on a consultation basis.

It is worth noting that in both these states, Washington and Oregon, the medical service bureaus operating under county medical societies have been developed against a background of "contract practice" for industrial accidents and ordinary illness. Therefore, medical service agreements are drawn between the employer and the bureau.

•

Under the Workmen's Compensation laws, agreements may be financed either by the employer paying the sum to the state, which in turn remunerates physicians and hospitals according to an established fee schedule, or through contracts with hospitals or doctors. Both states permit employers to make payroll deductions for general medical services to employees, provided a certain proportion of the employees agree to the plan.

•

Up until recently, most health insurance contracts in the United States have been made with hospital associations serving as middlemen or brokers. These agreements frequently involve large numbers of workers. Employees under contract with any one organization range in number from several thousand upward, one group being reputed to have had in 1930 approximately 60,000 subscribers.

It is but natural that the directors of the comparatively new medical service bureaus, all of them physicians, should secure the services of lay managers already thoroughly familiar with the problems of voluntary health insurance and the certification of cases for payment from a central fund. The promotion of annual service agreements is handled through salaried sales forces. In Seattle and Portland the management and sales activities are supervised by former government employees who have had to do with the administration of the Workmen's Compensation or Medical Aid laws in Washington and Oregon.

Any member of the county medical society may participate in the activities of his local bureau. Seattle's organization stipulates that all other previously held annual medical service agreements

shall be relinquished. Company physicians for railroads, mines, or lumber camps are exempted from this ruling.

Incidentally, "bureau doctors" agree not only to serve subscribers to the plan, but also to treat *bona fide* charity cases referred to them by bureau officers.

•

One bureau plans to provide medical care to subscribers' families and to individual employees who are not members of eligible groups. Another is considering separating hospital benefits from medical service benefits, this idea growing out of the active interest shown by hospital trustees and administrators in group payment plans for hospital care, as officially sponsored by the American Hospital Association.

The taking over of responsibility for hospital benefits by hospital or civic groups would, of course, help rather than hinder the development by county medical societies of group payment plans for physicians' services.

As operated at present, these medical service bureaus of the Pacific Northwest have fee schedules representing costs somewhat above the expenditures incurred by hospital associations and clinics.

This is to be accounted for partly because of the fact that they have been anxious to accumulate a cash reserve to be drawn upon for later distribution. Consequently, thus far, all services rendered by their participating physicians have not been paid for at par by the bureaus.

Doctors, hospitals, nurses, and druggists are supposed to be paid according to a fee schedule similar to that established for services rendered under the state compensation laws. However, hospitals, nurses, and druggists are paid first. Full payment is *not* guaranteed to the doctors—theirs is the remainder. Whether they are paid in full for their services or on a proportionate basis de-

pends upon the available surplus after the others have been compensated.

Participating physicians, having agreed to accept such proportionate payments in full, are not allowed to collect additional amounts from subscribers.

Nevertheless, in each of these communities more than half the local medical profession are participating. They feel that the non-profit organization will in the long run make possible at lower cost a higher quality of service than the individual "contract doctors" can provide.

Because the plan keeps the patient under the supervision of the physician of his choice and maintains undisturbed the relationship between the doctor and the subscriber's family, local members of the profession declare themselves satisfied with the general arrangement, even though payments are not always forthcoming strictly according to the fee schedule.

Steadily the number of subscribers to these plans is increasing in each of the localities where they are being operated. New enrollments of employees are made under existing employer-bureau agreements, and additional agreements are entered into with other employed groups.

•

And so, if the Pacific Northwest is any criterion, that "bold, persistent experimentation," so characteristic of our national policy today, can truly be said to have invaded the sphere of medicine.

For the Washington and Oregon plans differ from all similar projects in an especially signficant respect: They are *physician-owned* and *physician-controlled.*

The growing demand of the public that it be provided with adequate medical service on terms it can afford is being met by prompt *action.*

And it is action inspired by *medical* rather than by *lay* leadership!

The Ideal Laxative for Chronic Constipation

Careful experiments show that the swelling power of SARÁKA is many times as great as other bulk producing materials, such as psyllium seed and agar-agar.

SARÁKA contains a small amount of cortex frangula and acts as a stimulus to the intestines. The combination of the swelling power and this stimulus results in **bulk plus motility** so necessary for the production of a physiological action of the bowels. Ask for your sample.

SARÁKA is made in the United States by

SCHERING CORPORATION NEW YORK N.Y.

Literature & Samples

SAMPLES OF OANDA OINTMENT: This product is described as a healing and anesthetic ointment, containing Oleothesin in a base of animal and vegetable oil. For literature and samples, address a card or letter to the Oleothesin Co., Inc. (ME 3-34), 68-70 E. Utica St., Buffalo N. Y.

●

REPRINTS ON THE TREATMENT OF ARTHRITIS: Physicians are offered reprints of four articles having to do with arthritis and its treatment through the use of colloidal sulphur: Disturbed Sulphur Metabolism, a Factor in Chronic Arthritis abstracted from the British Medical Journal, October 3, 1925; Results of Treatment of Chronic Arthritis and Rheumatoid Conditions With Colloidal Sulphur, reprinted from the Journal of Bone and Joint Surgery, January, 1934; The Cystine Content of the Finger Nails in Arthritis, from the same source; and The Use of Colloidal Sulphur in the Treatment of Arthritis, from the same journal, January, 1935. For your copies address the Doak Company (ME 3-34), 2132 E. 9th Street, Cleveland, Ohio.

●

BRULE PULLMAN SYRINGE KIT: Literature describing this fountain syringe outfit stresses the point that it is an accessory which 400 physicians helped to design. While having a full two-quart capacity, it is so small that it can be slipped into a coat pocket. In the doctor's bag, it occupies very little room, and is not subject to damage by loose instruments. Write Brule & Company, Inc. (ME 3-34), 87 South High St., Akron, Ohio.

●

OXYGEN THERAPY APPARATUS AND EMERGENCY RENTAL SERVICE: Here is a neat little booklet which is, in effect, a combination manual and catalog. The pages are so arranged that it serves as a reference booklet in which one may see at a glance the proper equipment to be used (and the terms on which they may be purchased or rented) in the various cases calling for the use of oxygen therapy apparatus. Address the Ohio Chemical and Manufacturing Co. (ME 3-34), 1177 Marquette St., N.E., Cleveland, Ohio.

●

COVERED WAGON TRAILERS: This folder describes most attractively the particular advantages of this lightweight, compact unit, built for comfortable travel and living. Full specifications are given, and several photographs convey a very fair idea not only of the outside appearance, but of the interior in use as living room, bedroom, kitchen, and dining room. Address the Covered Wagon (ME 3-34), 14600 E. Jefferson Ave., Detroit Mich.

●

ORTHALETIC PLASTER: Here is an illustrated, attractively printed booklet describing what is said to be the first adequate plaster especially designed for orthopedic and athletic strapping. By photographs and special notes it demonstrates to the reader the proper way to treat various injuries calling for strapping. For a copy, write the Bay Company (ME 3-34), Bridgeport, Conn.

●

GUIDES TO HEALTH AND COMFORT: Here is a 15-page booklet containing interesting information about hygrometers and humidiguides, instruments to be used in securing proper air conditioning. Literature is available from the Taylor Instrument Companies (ME 3-34), Rochester, N. Y.

●

CORRECT STERILIZATION: This 15-page booklet describes through the use of both pictures and text a working technique for safe sterilization, said to be practical for the use of physicians and surgeons in their offices and clinics. A postcard or letter to the Wilmot Castle Company (ME 3-34), Rochester, N. Y. will bring you a copy.

●

NEW GEM BONE CONDUCTION HEARING AID: The latest development in hearing devices using the bone conducting principle is set forth in this literature which claims for the new instrument that it is light-weight, inconspicuous, and efficient, with amplified power and clear tone. Write the Gem Ear Phone Co., Inc. (ME 3-34) 47 West 34th St., New York, N. Y.

●

TRICHOMONAS VAGINALIS: Literature on the control and elimination of this troublesome and persistent condition through the use of the new product known as Trichomonicide is available to physicians by addressing William H. Rorer, Inc. (ME 3-34), 265 South 4th St., Philadelphia, Pa.

●

SU-COL: The indications for and the therapeutic effect of a physiologically

active colloidal sulphur bath are set forth in this leaflet. Su-col is said to be particularly valuable in securing relaxation and rapid relief from the pain or itching which the arthritic or rheumatic is likely to experience. Address the Drug Products Co. (ME 3-34), 26-32 Skillman Ave., Long Island City, N. Y.

●

UNDERWOOD SUGGESTS A PRESCRIPTION: For the otherwise up-to-date office where the old-fashioned laborious method of writing bills, formulae, correspondence, and prescriptions by pen is still in vogue, this leaflet suggests the use of the typewriter. And for a quieter office, where a typewriter is to be used, it urges the noiseless portable, equipped with a medical keyboard. For literature address the Underwood Elliott Fisher Company (ME 3-34), 342 Madison Ave., New York, N. Y.

●

ABBOTT'S BREWER'S YEAST TABLETS: According to this folder the product named, thanks to its content of vitamins B and G, is of medicinal value for stimulating the appetite and growth, for supporting intestinal functions, for its beneficial effects on lactation, and for the prophylactic treatment of conditions arising from dietary deficiency of these vitamins. Write the Abbott Laboratories (ME 3-34), North Chicago, Ill.

●

HYLAC—A MODIFIER OF COW'S MILK FOR INFANTS: A large, elaborately illustrated booklet discusses the comparative value of this new milk modifier. Copies may be obtained from Nestle's Milk Products, Inc. (ME 3-34), 2 Lafayette St., New York, N. Y.

●

SAMPLES OF TITRO DIETETIC SALT: For patients confined to a salt-free or salt restricted diet, here is a seasoning that should assure palatable foods. A combination of sodium, calcium, potassium, and magnesium salts, it is said to taste just like table salt. Several abstracts discussing it may be obtained from the Nordmark Chemical Works, Inc. (ME 3-34), 66 Leonard Street, New York, N. Y.

●

MILK IRRADIATION: Literature giving full information and scientific data on the subject of milk irradiation, a comparatively new process available through licensed dairies by the use of C.P. milk irradiators, may be obtained by addressing a request to the Creamery Package Mfg. Co. (ME 3-34), 1243 W. Washington Blvd., Chicago, Ill.

Reciprocal Service? "No!"

[*Continued from page* 17]

poorer care and attention when he is sick than the layman. There's a reason. Doctors are human, and when they realize that they are spending a lot of time and labor with little hope of being either compensated or thanked, their interest lags.

Your example of the country doctor who was shot does not apply to the main question. In an emergency case, no physician would think of asking for pay. But when a doctor comes in to see me with a head full of neuroses based on a chronic prostatitis, and requires weeks and months of difficult treatment for which I am to get nothing in return, the situation is a very different one.

Give me a minute to recall the case of a neurotic doctor whom I treated successfully for six months massaging the prostate, applying local treatment through the urethroscope, administering diathermy, and what not. When he felt fine, when his neuroses had left him, he frankly declared that I was all right and knew my business.

The next day a boy brought me two 20-cent packages of cigarettes, with a card of thanks from the doctor. I gently returned the cigarettes with the notation that I did not smoke.

In thirty years of general practice this man has never sent me a case. I emphasize the fact because I feel that the only claim he could ever have had on my services would have resulted from his having shown sufficient friendship and confidence in me to send me a case occasionally.

Instead, he sent his cases to one of his fee-splitting gang. And when he needed good treatment for himself he came to me.

That case taught me my lesson. In similar situations now I tell my doctor-caller that I am going

to regard him as an ordinary patient, and expect him to pay me for my time. I make a reduction, of course, and generally let him fix the fee. To be sure, he may never come back, in which case I feel well rid of a nuisance. And that's that!

Reciprocal Service? "Yes!"

[*Continued from page* 16]

courtesy. The profession itself seems to be so sick right now that it couldn't possibly pay the bill for treatment anyway. What doctor today doesn't have a few good-sized headaches which aspirin can't touch?

You can no doubt imagine one of your colleagues worrying about how he's going to pay his landlord, the butcher, the baker; how he's going to get a much-needed coat or dress for his wife; how he'll pay for medical supplies. But can you conjure up in your mind a picture of this same doctor getting a bill of $200 from a colleague-obstetrician for delivering his last baby?

I can!

He tears the Oath of Hippocrates out of its gilded frame. By manual extraction he removes the few hairs remaining on his head. He takes off his collar to give his goitre a chance to enlarge. He mumbles and mutters to himself until some soft-hearted psychiatrist, alarmed at the cross-eyed Babinski and the exaggerated K-J's, gently leads him to a padded cell.

Don't think you're old-fashioned simply because, when you meet a colleague and go to lunch together, the joy of the occasion is killed when he remarks: "Let's make this Dutch." The type of physician who kills the charm of such a meeting by a remark like that is the kind who charges his colleagues for giving them medi-

cal attention. He is very much like the fellow who, invited to have a cigar, says: "Well, I don't smoke, but if it's all the same to you, I'll take a *Saturday Evening Post*."

If we abandon reciprocal service, Hippocrates will squirm in his grave! The caduceus will be transformed into a couple of rampant jackasses. And the members of the profession will have, or should have, a constant facial erythema—if you get what I mean.

Let well enough alone!

•

Contract Practice Under the Yoke

[*Continued from page* 51]

vidual members of the society the duty of requiring regular fees from all persons *capable* of paying them.

Physicians connected with the staffs of hospitals are strictly enjoined to charge the usual fees for medical services rendered to all persons seeking gratuitous services when they are able to pay. In general, it is recommended that members present their bills for professional services promptly after they have ceased to attend a case. And it is set forth as a duty of each member to obtain, if at all possible, a monthly settlement from all his patients.

Furthermore, the Board undertakes to regulate the charges imposed by members of the society.

An extensive fee table has been prepared for the guidance of physicians, listing the standard fees which shall be demanded. These fees are to be increased, according to the judgment of the practitioner concerned and in the light of the particular circumstances of the case.

They may, of course, be reduced at the discretion of the individual practitioner if he has reason to believe that the patient can not afford to pay the regular fees. But the Code and Contract Board stipulates plainly that reduction of fees except for motives of charity and benevolence is a violation of its regulations.

•

All in all, the establishment of the St. Louis Code and Contract Board represents an admirably direct and frank effort to cope with a situation which, in many sections of the country, requires drastic correction.

Both Sides of the Malpractice Muddle

[*Continued from page* 23]

ing for his medical care; this results in heavy costs to us . . . Claims have increased in recent years . . . The ambulance-chasing lawyer, the litigation-aggravating type, is more active today than ever before . . . The maximum number of physicians who could be insured does not produce sufficient premium volume to justify setting up the highly specialized investigation and legal facilities necessary for the successful handling of claims."

That mutual dissatisfaction exists is evident. Sober judgment dictates that some investigation of these charges and countercharges might clarify the situation.

Perhaps the company interests are to be criticized for too hastily concluding that they cannot profitably write this coverage. Facts and figures should determine this.

•

It is axiomatic that specialty forms of insurance coverage have generally proved costly to the companies offering them. That physician's malpractice is a specialty form is evidenced by the fact that not more than six or possibly eight companies issue such insurance at all; and, as we have already noted, three of these transact the great bulk of all the business. That many more have tried and failed is a historical fact.

Within the past year or so one of the "Big Three" companies is reported to have completely withdrawn from New York; and a second company, at one time a leader in this class, currently admits that efforts are being made gradually to terminate its outstanding policies.

If malpractice insurance constitutes a problem for the companies, are they to be blamed for

not troubling to acquaint the profession with their difficulties? Or have they actually presented their case, argued it out with the doctors, and found that the evils encountered are largely inherent in the nature of the risk assumed and beyond power of control? The latter position seems to be sustained by the findings.

•

Of the individual practitioner who voices a complaint against the existing order of things, it must be said that his conclusions are often founded upon a limited grasp of the problem. Because he himself has not been the victim of a malpractice suit nor heard of one within his own professional circle, he falls into the error of concluding that the risk assumed by the insurance companies is just not a reality. It is he who sets up the cry about the high cost imposed.

That so few companies write malpractice is noteworthy. It indicates that something is wrong somewhere.

To say that insurance companies operate for profit is only to state the obvious. Competition is admittedly keen among insurance companies for all forms of insurance protection commonly carried by the professional man—all, that is, except malpractice. In obtaining this coverage, the physician finds himself hampered by the inevitable restrictions of a limited market.

It can be conservatively stated that a majority of the established companies have at one time or another attempted to issue malpractice insurance. Sooner or later they stopped—and always for the same reason: Losses are excessive.

Not that there is an insufficient margin of profit—on the contrary, the trouble is that the claim cost outlay exceeds the gross premium income. [*Turn the page*]

There would seem, then, to be some merit in the contention that if a maximum number of doctors were to carry this form of protection, and if their policies were widely distributed among the three hundred-odd liability insurance writing companies—even then there would result such a small premium volume per company as not to compensate for the expense risk assumed.

Experience has taught the companies that highly trained investigators, and attorneys with an exhaustive and intimate grasp of medical jurisprudence are essential. These cost money, and plenty of it. Large premium revenue it would seem then is necessary to any company maintaining such specialized claim facilities on a country-wide basis.

•

In the late '20's a large number of new liability insurance companies were formed. Only one among a dozen such companies is known to have attempted malpractice coverage. This company, while it has not completely withdrawn from the field, has drastically curtailed its writings, and is today accepting such insurance only as an accommodation when the physician applying for it is prepared to purchase other forms of insurance "to absorb the inevitable loss on the malpractice policy."

It was this writer's good fortune, in contemplation of this review of malpractice, to secure from the head office of one of the "Big Three" companies some eye-opening statistics. These seem to bear out conclusively the companies' perennial complaint about losses.

On a nation-wide basis over a period of years, there have been 2.27 claims for every hundred physicians insured. A ridiculously small percentage!

Surely this one fact sustains the position of those who cry "racket!" Yes, if we admit as we must that the ratio of automobile

accidents or health insurance claims per hundred policies written is radically higher.

But, this company points out, the *cost per claim* is the kernel of the matter. Each of these 2.27 claims costs an average of $862—not in judgments paid (for judgments sustained by our higher courts against the medical practitioner are rare), but in court fees, special counsel fees, investigation costs, and expert testimony fees—all of which are inevitable and routine items of expense when the physician is sued.

Add to these a premium tax as imposed in the various states, plus a sales (agent's or broker's) commission of 17½ per cent, plus general administration expenses, and you begin to suspect that there is not much left for the stockholders out of an average premium of $32 or $34 from each of the one hundred physicians.

It may be argued that the expense items enumerated are common to all litigation. With the physician, two of these items present an unusual expense; expert testimony and special defense counsel.

•

A malpractice suit which this writer handled in part some time ago cost the defending insuring company some $1,900 simply for expert testimony fees, traveling expenses of the testifying specialist, and maintenance at a small town some eighty miles away.

To the criticism that a few companies have a monopoly on the business of malpractice insurance, it can be said that efforts made periodically to arouse the interest of the various companies in this form of coverage have met with a cold response. The non-writing companies are glad to "tolerate" the "monopoly." A few of them, to sustain their announced position of being "multiple line" companies (meaning that they offer *all* forms of liability insurance) accept malpractice at

rates about 30 per cent higher than the $32 a year charged by the "monopolistic" group.

Probably no class has been more affected by the depression than the physicians of this country. Hence, it is but natural that an increase in premium charges for a form of insurance which is often carried and tolerated only as a nuisance should meet with resistance.

On the other hand, the statistics of one company, whose figures may be accepted as representative, show that for the three worst years of the depression—1929 to 1932—60.3 per cent of every gross dollar received was paid out for investigation, defense, and judgment payments. And this does not mean 40 cents profit per dollar of premium. Far from it! To the 60 cents must be added the expense items previously referred to.

•

Several reasons can properly be assigned for this upswing in costs. It is a matter of record that in every period of bad times claim costs advance. People financially distressed, whose morals are not too inflexible, consider the insurance companies as "ready money."

Doctors, generally believed to be affluent, must have insurance, the unscrupulous assume; hence, trumped-up charges of malpractice increase in number. These charges lack merit, to be sure, but they add to the claims cost.

During the prosperity era that preceded 1929 the almost universal spirit of affluence that pervaded the country found its way into the courts of the land. Judges and juries let their fancies run wild. Verdicts out of proportion were the order of the day. The habit once formed has not been corrected during recent lean years.

Among a good many physicians the impression persists that county or state medical society membership is an absolute and arbitrary requirement for malpractice insurance. Investigation shows this to be only partly true.

Three large Eastern companies questioned on this point within the past few weeks state that in those sections of the country where they have group contract arrangements with local medical societies this requirement does apply. These group arrangements are welcomed by the companies because it relieves them of the necessity of individual investigation costs and reduces overhead by making it possible to conduct all negotiations with the society's board of directors. Where such arrangements prevail they do in fact bar the doctor who is not a local society member.

By way of defending this practice, the companies say that to accept such non-members would give rise to an individual investi-

gation cost that the group premium rate does not contemplate.

This contention seems to suggest an evasion of the real issue. The investigation cost is nominal, admittedly. It would be a simple matter if the companies cared to extend their facilities to nonmembers to add a premium differential the first year to cover investigation costs.

After all, though, the simple truth is that since malpractice insurance is looked upon by the liability companies as an "accommodation" to the profession, they feel no desire to extend their efforts in this direction any more than they have to.

Despite accusations to the contrary, an unprejudiced study of the facts indicates that non-membership in one of the "approved" societies is not interpreted by the insurance interests as a reflection upon professional skill or integrity. It is merely a necessary and arbitrary requirement, if you will, for malpractice insurance where it is issued on a group basis.

All the companies seem ready to agree that there are many skilled practitioners who are not members of any professional association. To these they freely extend their facilities in those communities where they are not under contract with the local society.

•

If any conclusion may be drawn from this analysis of present-day malpractice insurance, it would seem that there are and have been many misconceptions of the business, traceable either to the precipitate conclusions of physicians or to the half-hearted interest of the companies in a persistently non-profitable venture, which has led them to neglect telling their story to the "consumer."

Certainly it is safe to predict that there is nothing in the offing which holds much promise of rate relief for the profession or profit for the companies.

When the Doctor Becomes the Patient

[*Continued from page* 38]

day, either morning or afternoon, or may go for an hour or two every morning, long enough to feed, bathe, and rub the patient, change the bed and leave him refreshed, or carry out any orders which the doctor may have left for her. There are great possibilities for the patient's comfort in such an arrangement and it is a question if the nurses themselves are not overlooking a great opportunity in this field.

These comprise only a few suggestions of the changes which we ourselves can make. It doesn't require a course in higher mathematics to understand that the present situation is satisfactory to no one. Under such circumstances patients are forced to delay operation, to treat themselves, and to put up with inadequate care from which nobody benefits.

It is hardly necessary to point out the danger to ourselves from conditions as they are now. It is, however, well for us to remind ourselves that community hospitals are, after all, financed by the public; and no one can doubt that the time is near at hand when funds will be increasingly difficult to obtain unless we can show people that the hospitals are intended primarily for the sick rather than as training schools for nurses and doctors, or as laboratories for a better understanding of disease.

It is not a reflection upon our ability so much as upon our good sense that the scientific appeals of medicine have too often made of our patients mere shadows hovering in the background. We have more at stake than most professions, for we not only have to fight the competition of the various cults, the bold promises of which attract and trap the unwary, but we have the Govern-

ment working against us also in its establishment of free hospitals for the care of veterans. And if these things were not enough, the spectre of State medicine confronts us.

Through the lack of a concerted plan for our own and our patients' protection, and because of our intense preoccupation with disease, we have been exploited by alien efforts to standardize medicine, to make it a business chain in which we shall be merely hirelings and the relationship between patient and doctor destroyed.

I believe that we ourselves through the rich resources of the national, state, and local societies, can find a way of stabilizing costs through economy in hospital management, cheaper nursing facilities, partially endowed private rooms, and finally by the launching of an offensive to teach the importance of periodic physical examinations.

•

A Dentist Works With Me

[*Continued from page* 41]

life-size model of the jaw, cut away at one place to illustrate the anatomy of nerve supply, blood supply, and so on. Another portion of the model was used to illustrate most interestingly and instructively some of the phases of dental caries.

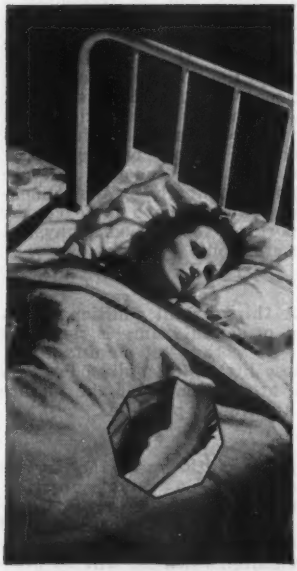
The model is used with a brush for showing how the circular motion in brushing the teeth gives the desired up-and-down action that is so useful in removing debris that the usual horizontal motion leaves undisturbed. It fits into the instruction work in a dozen other useful ways.

A third useful addition was a box of dental samples, supplied by a toothpaste manufacturer. These little gifts bulked large in the attractiveness of the picture to the young patients.

•

Here is the way the service works out, in actual practice: Each patient seen in the Clinic in the course of the week is told casually that on a certain day a children's dentist will be present, for the purpose of making an examination of any child who may be brought to him.

It is distinctly explained that no charge is to be made for this examination service, provided that alone is given. Perhaps half the parents are glad to avail themselves of this opportunity to



When Seconds Count

an ampule of CORAMINE *"Ciba"*

meets the most exacting requirements. In emergencies you will find its action prompt and effective. In cases where it is to be given over a relatively prolonged period, you will find it just as effective. **Clinical results have shown Coramine, "Ciba", of inestimable value in pneumonia, chronic myocardial involvement, accidents from anesthesia or poisoning by cresol, morphine, barbiturates, or illuminating gas.**

In all forms of dosage Coramine, "Ciba", promptly overcomes depression of the respiration and simultaneously stimulates the circulation.

LIQUID **AMPULES**

Write for literature and samples

CIBA COMPANY, Inc.
NEW YORK, N. Y.

ERGOAPIOL (SMITH)

Amenorrhea - Dysmenorrhea
Menorrhagia - Menopause

Today, as for years, Ergoapiol (Smith) is the accepted medicament in combating those menstrual anomalies which may be traced to constitutional disturbances; atonicity of the reproductive organs; inflammatory conditions of the uterus or its appendages; mental emotion or exposure to the elements.

The physician readily can ascertain whether his prescription for Ergoapiol (Smith) has been correctly filled by dividing the capsule at the seam, thus revealing the initials M. H. S. embossed on the inner surface, as shown in photographic enlargement.

Literature on Request.

MARTIN H. SMITH CO···150 LAFAYETTE ST···NEW YORK CITY

have their children's teeth receive a thorough cleaning. The fee is small, usually a dollar for this service.

During the examination an honest effort is made to get across just as much information upon this fascinating topic of dental hygiene and dental development as parent and child can absorb.

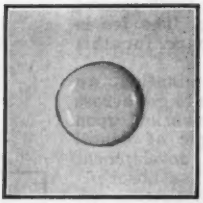
Many of these youngsters are found to have teeth in splendid condition and so require no attention whatsoever. Yet even these children profit by some instruction, as well as by the assurance that nothing further needs to be done for them. If the parents want it, a copy of the dental record is given them; another, if they so desire, is sent to the home dentist.

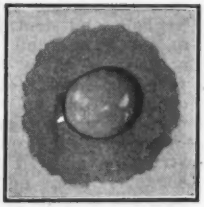
Those parents whose children need a prophylactic treatment in addition to the examination usually have this done while the child is in the chair. The cost is small; and yet, in the course of an afternoon, it may mount up so as to be worthwhile for the dentist doing the work.

A fair proportion of the children examined are found to be in need of reparative dentistry. In such cases, no pressure is exerted to urge having this work done. In fact, since there are no facilities here at the Clinic for doing any sort of repair work whatever, it is a perfectly simple matter for even a sensitive parent to let the matter drop right there.

It is well-known that a great

NOW YOU SEE AGAROL





. . . NOW YOU SEE SOMETHING ELSE

THE RING around the drop tells the story. A drop of Agarol on blotting paper holds together firmly. Try this with a poor emulsion, and you will see that the mineral oil will be soon taken up by the blotting paper, forming a greasy ring around the drop.

Agarol is as fine an emulsion of mineral oil and agar-agar with phenolphthalein as the modern art of pharmacy, aided by the skill of experience acquired in more than three-quarters of a century can produce. It never leaves an oily taste.

Finest, purest ingredients make Agarol palatable without artificial flavoring. It contains no sugar, no alcohol, no alkali.

For dependable efficacy Agarol has attained a reputation all its own, generously granted by those who have observed its good effects in the resultful treatment of constipation.

Trial supply sent on request. ★ ★ ★ Please use letterhead.

AGAROL FOR CONSTIPATION

Agarol is supplied in bottles containing 6 and 14 ounces. The average dose is one tablespoonful.

WILLIAM R. WARNER & CO., Inc.
113 West 18th Street, New York City

many dentists will get out of doing work with children if they possibly can. Knowing this, parents are generally glad to find a dentist who not only is willing to treat children, but is actually going out of his way to find such work.

•

Knowledge of the child's dental condition is part of the complete picture of the child's health that every pediatrician should have in his profession. If he fails to get the results he has a right to expect from his treatment, despite the changes he institutes in the child's regimen, it is possible that the clue may exist in the neglect of dental work that has been suggested. And he can follow out this clue when his records show the exact dental condition present.

There are still other ways in which the help of the dentist in these routine cases is especially valuable both to parents and the pediatrician. I recall one mother who was in serious doubt as to the soundness of the orthodontal work being carried on. The dentist was able to reassure her.

Various forms of periodontal treatment, while of course not nearly so common in children as in adults, still crop up from time to time. And it is a comforting feeling to have expert knowledge so readily available.

Even that old question of lancing the gums for delayed dentition, when it is causing temperature and pain, comes up occasionally. The opinion of the dentist receives respectful consideration by worried parents. Charges are occasionally made for such consultation services as these.

•

Certain suggestions for future work made themselves obvious in the course of our first season of experimental dental work. We shall incorporate the indicated changes in our subsequent practice.

For example, we have found that we should have two afternoons a week instead of one, in the rapidly shifting summer resort population with which we have to deal here. Also, we should maintain absolutely regular hours, even at the very first, instead of trying to make sure that there are cases enough to justify the dentist's trip out from town. More than once cases were lost last summer because I was not sure there would be a full afternoon's work, and so hesitated to make definite appointments.

I feel confident that we should prepare ourselves to have simple reparative work done here at the Clinic this coming season, instead of insisting that these cases go into town for treatment.

While of course anything serious can be handled in the dental office far better than here (the short season makes the equipment of a modern dental office in the Clinic out of the question), still it was found last year that quite a bit of work failed to be done that could have been taken care of quite satisfactorily had we been equipped to deal with it as soon as it was discovered.

[*Turn the page*]

As the volume of work increases, a dental hygienist or office assistant should unquestionably accompany the operator. She can more than double his efficiency. Records kept and properly filed by her are a great satisfaction. Then, too, the presence of a young woman trained to deal with children is a great asset in such work.

How elaborate an equipment will be necessary for dealing with repair work here on the spot? The very elementary but perfectly satisfactory outfit possessed by school dentists will no doubt serve well enough.

Fillings in deciduous teeth, simple repair work in permanent teeth, removal of small carious teeth with roots almost completely absorbed, opening and treating of infections—all these things can be done satisfactorily with the portable dental outfit that has given such excellent service in the schools.

An expensive dental office is not necessary. Any work that demands more equipment than can be transported easily should be referred to the dentist's own office, as should anything requiring X-ray examination or special treatment.

Not only economic benefit to the dentist but practical considerations of efficiency to the young patient and his parents would indicate that just as much of this

work should be done at the Clinic as can be satisfactorily taken care of.

There is no doubt that the dental profession should work in closer harmony with the medical. This is constantly being stressed in the journals of both professions. The plan here outlined bids fair to satisfy the practical demands of such teamwork. For it benefits all three parties to the transaction: the dentist, the doctor, and the youngster who is being treated.

•

All Give And No Take

[*Continued from page* 13]

Then came three afternoons a week from two to six in a dispensary. The other three afternoons, as well as many nights, I spent in the pathological laboratory of a hospital, working up cases. Net results: first year, $1,000; second year, $2,000; third year, $3,000. I then married after a ten years' engagement, but still went on doing free work, putting in every afternoon at a dispensary or a hospital.

Ben Franklin's thrift advice eventually worked out, however. By the time I was 40 there was enough laid by for me to spend two years in Europe, still an optimist. I returned with nothing but my optimism—Mother Hubbard's cupboard had nothing on me.

But those 72-hour periods without sleep had taught me that there were all sorts of other things I could do without, including the various dice games that keep improvident the people who believe in getting something for nothing.

Then came five children, and another hitch in the belt, and some more days of sixteen and more hours' work of which at least four or five were given for nothing. And all during this time the fanatical idea persisted that the experience I was securing in this way was more important to me than building a practice!

Nary a patient did I ever get from either the hospital or the dispensary. So it went on until I became sixty years of age.

•

Count up the hours if you will —I don't intend to. Things that are past are past, save for the happy memories of being interested. Of course, when one is sixty it is high time to realize

that all give and no take butters no parsnips.

Still I am not hard-boiled. We have a roof over our hands—unmortgaged. We have had hard knocks enough to strip some of the teeth in the old gear-box. But we continue to rattle on!

Strangely enough, I never did get unduly flim-flammed by the "good business men"—bankers and lawyers—although I am a bit bruised, to be sure.

And as I approach the patriarchs' time limit, people still seem to think I can be of service to them!

•

Can the Doctor Advertise?

[*Continued from page 47*]

cians, last October the question of dental advertising, arising at the same time on the east coast and the west coast, was settled in such a way as to show that the courts still view this type of advertising in the same light.

In Oregon an advertising dentist failed in his attempt to secure an injunction against the enforcement of the state law limiting and regulating advertising by dentists.

And in New York, Attorney-

General Bennett held constitutional a ruling of the State Board of Regents, made last March, which restricts the advertisement privileges of dentists to the use of a small professional card only.

At first it was considered that the regular communications from dentists to their regular clientele, the more or less standardized forms sent out at stated intervals to remind patients that six months have elapsed since their last visit, also fell under the ban.

However, according to Dr. Minor J. Terry, of the New York State Board of Dental Examiners, this is not the case.

"By carefully reading this rule," says Dr. Terry, "you will notice that making use of any advertising device for the purpose of *soliciting* patronage is the only thing prohibited. There is no intent on the part of this department, or the board of dental examiners, or the attorney general, or anybody else who has to do with the administration of this rule, to interfere with any communication between a dentist and his clientele. This rule was framed for the purpose of controlling *solicitous* dental advertising of a nauseating character."

•

Thus the question as to whether the individual physician may advertise seems definitely settled in the negative. But may physicians advertise as a *profession?*

As already stated, the answer is *yes.* It may be done, it has been done, and it is being done right along.

In New Jersey, for instance, the Bergen County Medical Society has engaged in so-called "blanket" advertising. And this past fall two other groups, the Cook County Medical Society and the Philadelphia County Medical Society, began to lay rather extensive plans for advertising designed to uphold trustworthy medical men as against quacks and charlatans.

Where to Find Our Advertisers

● Drybak, the waterproof adhesive plaster, makes strappings that are more practical, and less conspicuous. Its glazed surface keeps clean.

The edges of Drybak will not turn up after washing. When the plaster is removed there is practically no residue left on the skin. Drybak is suntan in color, and is therefore much less conspicuous than white adhesive plaster. In cases of visible strappings, patients, especially women, will appreciate the use of Drybak.

Drybak is supplied in cartridge spools in all standard widths, in Band-Aid 1" x 3", in Hospital Spools, 12" x 10 yds., assorted widths, and Hospital Rolls, 12" x 5 yds., uncut. Order from your dealer.

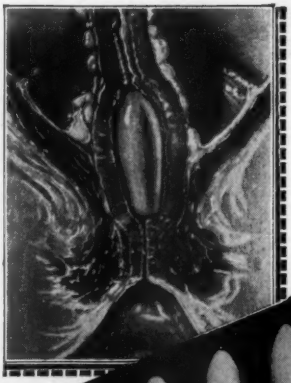
. . . and costs no more than white adhesive plaster

DRYBAK ADHESIVE PLASTER

PROFESSIONAL SERVICE DEPARTMENT

Johnson & Johnson

NEW BRUNSWICK, N. J. CHICAGO, ILL.



ANATOMICALLY CORRECT

WYANOIDS

(Wyeth's Hemorrhoidal Suppositories)

The torpedo shape allows the insertion of the pointed end first. As the widest diameter passes the sphincter muscle, the Wyanoid spontaneously moves inward where it is retained, melted and the therapeutic ingredients liberated.

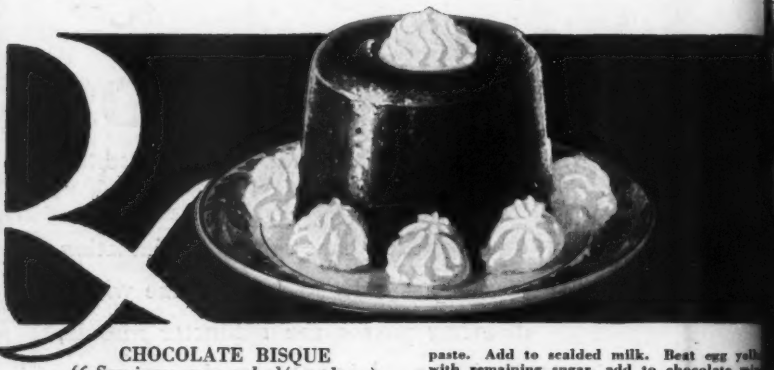
Wyanoids quickly allay pain, reduce inflammation, restrict bleeding.

JOHN WYETH & BROTHER, Inc.

PHILADELPHIA, PA. and WALKERVILLE, ONT.

Doctor . . . . Your Cook Can Fill This Prescription

Thousands of physicians have found Knox Sparkling Gelatine of value in special diets—and for specific purposes—but have you tried your own medicine? Just ask your cook to fill this prescription by dinner-time tonight. We promise you will respond to the treatment quickly and enthusiastically—and also increase your preference for dishes made with Knox *plain* Gelatine over those made with "factory-flavored" brands.



CHOCOLATE BISQUE

(6 *Servings—uses only* ¼ *package*)

1 envelope Knox Sparkling Gelatine
¼ cup cold water
1 cup scalded milk (not boiled)
2 eggs
½ cup sugar
¼ teaspoonful salt
1 cup cream or evaporated milk (whipped)
2/3 cup macaroons or chopped nuts
1 teaspoonful vanilla
1 square chocolate

Melt chocolate and mix with part of the sugar and a little milk to make a smooth paste. Add to scalded milk. Beat egg yolk with remaining sugar, add to chocolate mixture and cook in double boiler until mixture coats spoon. Pour cold water in bowl and sprinkle gelatine on top of water. Add to hot custard and stir until gelatine is dissolved. Cool, and add whipped cream or whipped evaporated milk, vanilla and salt. Fold in whites of eggs beaten until stiff, and pour into glasses or mold that have been rinsed in cold water. Chill, and when firm unmold. Sprinkle tops with dried and rolled macaroons or chopped nuts. Three tablespoonfuls cocoa may be used instead of the chocolate. This may be frozen in tray of mechanical refrigerator.

Knox Gelatine Laboratories
448 Knox Ave., Johnstown, N. Y.

Please send my wife your recipe books. Please send me dietetic information on plain gelatine.

Name.....

Address.....